

2725

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Butler	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reisterstown Rd.		d. STREET ADDRESS Belfast Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bret Middle Gray Last Adams		4. DATE OF DEATH Month 3 Day 12 Year 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10--12-58
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 5 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel S. Adams III		14. MOTHER'S MAIDEN NAME June Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. none	
17. INFORMANT Father		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Respiratory Infection 492X DUE TO Pneumonitis (left lung) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Convulsion (c) Convulsion INTERVAL BETWEEN ONSET OF DEATH AND CAUSE OF DEATH 3-12-59 3 days 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-8-59 , 19 59 , to 3-12 , 19 59 , that I last saw the deceased alive on 3-12 , 19 59 , and that death occurred at 3:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 3-14-59 ACTUAL SIGNATURE M. C. Porterfield M.D. PHYSICIAN'S NAME (Type) M. C. Porterfield Hampstead, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-14-59	22c. NAME OF CEMETERY OR CREMATORY Black Rock	22d. LOCATION (City, town, or county) (State) Butler, Md.
23. FUNERAL DIRECTOR'S SIGNATURE I Scott Brooks		24a. REC'D BY REGISTRAR DATE MAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Harris

2047242xv4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

104-105-106

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

555

77-0452-2

1. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02694

2726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>2665 W Park Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E.</u> Last <u>Amersbach</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-74</u>	9. AGE (In years full birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Congestive heart failure</u> DUE TO (b) <u>Generalized arteriosclerosis with aortic and mitral stenosis</u> DUE TO (c) <u>Chronic rheumatic heart disease - decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Mar. 10</u> 19 <u>59</u> to <u>Mar. 15</u> 19 <u>59</u> that I last saw the deceased alive on <u>Mar. 15</u> 19 <u>59</u> and that death occurred at <u>6:55 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.D. Drinkard</u>				ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u>			
DATE SIGNED <u>3-16-59</u>							
PHYSICIAN'S NAME (Type) <u>James Donald Drinkard, M.D.</u>				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North Ave. Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leo B. Coker, Jr.</u>				ADDRESS <u>101 Patterson Pl.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2727

CERTIFICATE OF DEATH

Reg. Dist. No.

02695

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (29) 3Y01-4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3924 Gelston Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last ANDERSON				4. DATE OF DEATH Month March Day 19 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1871		9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Stockholm, Sweden		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Anderson				14. MOTHER'S MAIDEN NAME Clara Erika			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) SAV		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 420.1 DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET OF DEATH 1 HOUR RECENT							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) G. I. BLEEDING							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 19 59 , to March 19 19 59 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND				DATE SIGNED 3/19/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				ADDRESS 6009 Harford Rd., Baltimore Md.		24a. REC'D BY REGISTRAR MAR 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECORDED

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of attending physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2728

CERTIFICATE OF DEATH

02696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1421 South Charles Street	
3. NAME OF DECEASED (Type or print) First HARRY Middle F. Last ANDREWS		4. DATE OF DEATH Month March Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1891
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hydraulic Presser	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Harry F. Andrews	
14. MOTHER'S MAIDEN NAME Ida May Lambright		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 212-05-8626		17. INFORMANT Address Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMATOSIS, PRIMARY SITE UNDETERMINED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 WEEK UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA
20f. (City or town) Baltimore		20g. (County) (State)	
21. I certify that I attended the deceased from March 4, 1959 , to March 11, 1959 , and that death occurred at 5:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 3/11/59			
ACTUAL SIGNATURE John W. Crawford M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 16/1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE A. Howard Evans ADDRESS 1400 S. Charles Street Baltimore Maryland		24a. REC'D BY REGISTRAR APR 12 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

1900

Form No. 1

Blank form with horizontal lines for text entry.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02697

2729

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>12yr5mth9dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>			
f. STREET ADDRESS <u>1623 Milton Avenue</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Charles</u> Last <u>Arthur</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Edwin Arthur</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Stengel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>4222</u> DUE TO <u>Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malignant Growth Confined to the Lymph Nodes, probably Lymphosarcoma</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 16, 1958</u> to <u>March 18, 1959</u> , that I last saw the deceased alive on <u>March 18, 1959</u> , and that death occurred at <u>8:30a. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D.				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>3-18-59</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-21-59</u>		<u>Baltimore Cemetery</u>		<u>North Ave Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leslie Cook</u> ADDRESS <u>100 North Ave Balto Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

100-100000

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of crematorium		18. Signature of cremation		19. Signature of cremation		20. Signature of cremation	
21. Signature of cremation		22. Signature of cremation		23. Signature of cremation		24. Signature of cremation	
25. Signature of cremation		26. Signature of cremation		27. Signature of cremation		28. Signature of cremation	
29. Signature of cremation		30. Signature of cremation		31. Signature of cremation		32. Signature of cremation	
33. Signature of cremation		34. Signature of cremation		35. Signature of cremation		36. Signature of cremation	
37. Signature of cremation		38. Signature of cremation		39. Signature of cremation		40. Signature of cremation	
41. Signature of cremation		42. Signature of cremation		43. Signature of cremation		44. Signature of cremation	
45. Signature of cremation		46. Signature of cremation		47. Signature of cremation		48. Signature of cremation	
49. Signature of cremation		50. Signature of cremation		51. Signature of cremation		52. Signature of cremation	
53. Signature of cremation		54. Signature of cremation		55. Signature of cremation		56. Signature of cremation	
57. Signature of cremation		58. Signature of cremation		59. Signature of cremation		60. Signature of cremation	
61. Signature of cremation		62. Signature of cremation		63. Signature of cremation		64. Signature of cremation	
65. Signature of cremation		66. Signature of cremation		67. Signature of cremation		68. Signature of cremation	
69. Signature of cremation		70. Signature of cremation		71. Signature of cremation		72. Signature of cremation	
73. Signature of cremation		74. Signature of cremation		75. Signature of cremation		76. Signature of cremation	
77. Signature of cremation		78. Signature of cremation		79. Signature of cremation		80. Signature of cremation	
81. Signature of cremation		82. Signature of cremation		83. Signature of cremation		84. Signature of cremation	
85. Signature of cremation		86. Signature of cremation		87. Signature of cremation		88. Signature of cremation	
89. Signature of cremation		90. Signature of cremation		91. Signature of cremation		92. Signature of cremation	
93. Signature of cremation		94. Signature of cremation		95. Signature of cremation		96. Signature of cremation	
97. Signature of cremation		98. Signature of cremation		99. Signature of cremation		100. Signature of cremation	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

2730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL (TOWNSHIP)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JESSUP, MD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 602 VALLEY VIEW ROAD		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDITH First ADAMS Middle ATTERBURY Last		4. DATE OF DEATH Month MAR Day 6 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1869	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ORSON ADAMS		14. MOTHER'S MAIDEN NAME ANNIE FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HOWARD ADAMS JR. Address 602 VALLEY VIEW RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 4771 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic Cardiovascular disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 mos -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from 12-6-1958 to 3-6-1959 , that I last saw the deceased alive on 2-28-1959 , and that death occurred at 7:15 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 1101 St Paul St Baltimore MD DATE SIGNED 3-6-59					
ACTUAL SIGNATURE Alfred G. Ossman		PHYSICIAN'S NAME (Type) H.W. JENKINS & SONS CO. 4905 YORK RD, BALTO. MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-9-1959	22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	22d. LOCATION (City, town, or county) BALTO.	(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS CO.		ADDRESS 4905 YORK RD, BALTO. MD		24a. REC'D BY REGISTRAR DATE MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. H...

VS A15 (4)
15M 10/57



02699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore			MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institut an Residence before adm ission) a. STATE Maryland			b. COUNTY Queen Annes		
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 12 1/2 Hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 402 North Commerce Street								
3. NAME OF DECEASED (Type or print) First ALEXANDER			Middle ---			Last AYERS			4. DATE OF DEATH Month March		
5. SEX Male			6. COLOR OR RACE Colored			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 8, 1891		
9. AGE (In years last birthday) 67			IF UNDER 1 YEAR Months Days			IF UNDER 24 HRS. Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver			10b. KIND OF BUSINESS OR INDUSTRY School Bus			11. BIRTHPLACE (State or foreign country) Centreville, Maryland			12. CITIZEN OF WHAT COUNTRY U. S. A.		
13. FATHER'S NAME Charles H. Ayers						14. MOTHER'S MAIDEN NAME Rebecca Hayman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO WW I			17. INFORMANT 214-34-7373			Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	HYPERTENSIVE HEART DISEASE	
443X	DUE TO	UNKNOWN
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.	(b)	
	DUE TO	
	(c)	

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

MEDICAL CERTIFICATE	20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)	(County)

21. I certify that I ~~did~~^{did not} attend the deceased from 9:00 AM 3/16, 1959, to 9:30 PM 3/16, 1959, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

ACTUAL SIGNATURE Donald D. Mark M.D. VAH, FORT HOWARD, MARYLAND 3/17/59

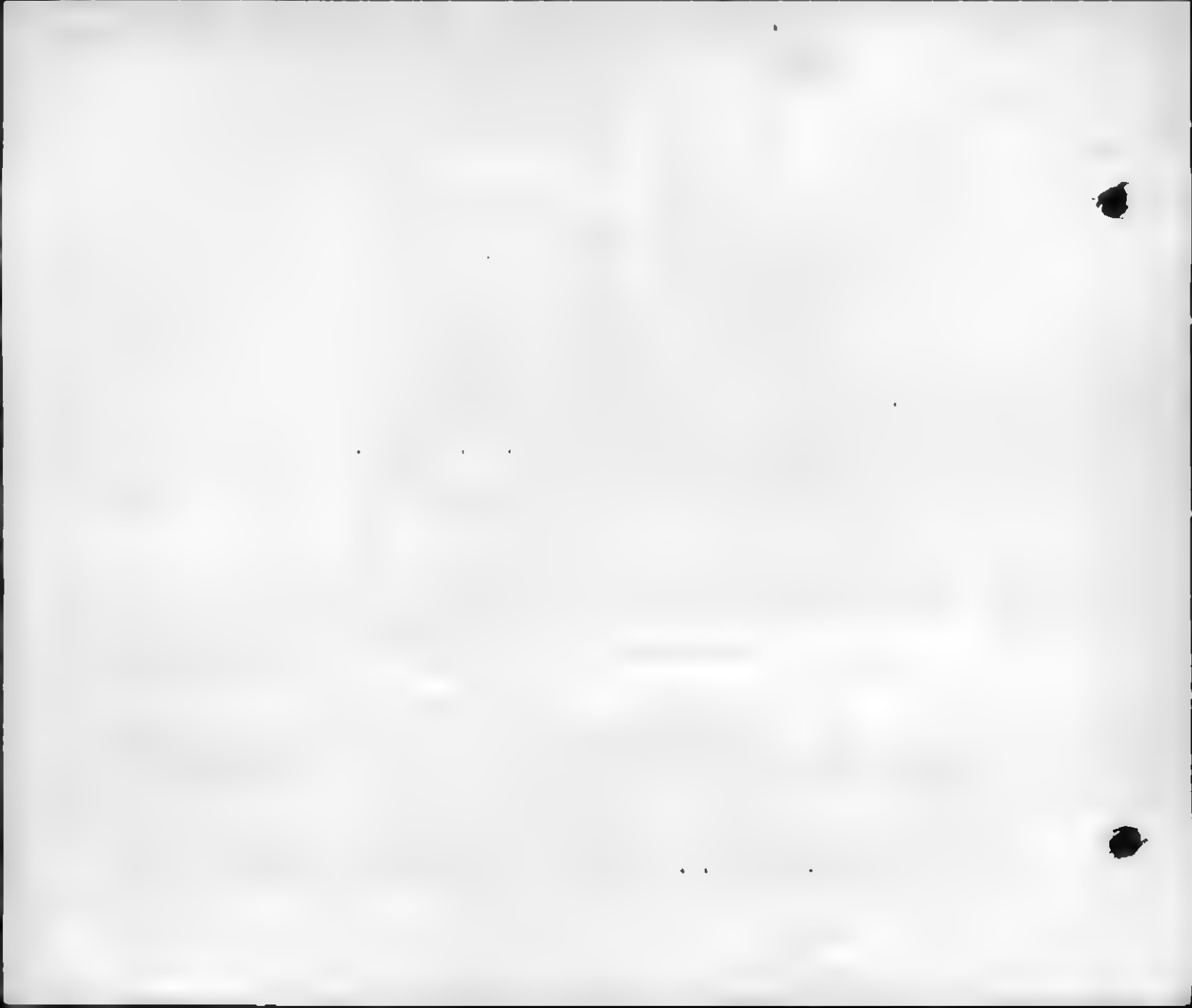
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D. VAH, FORT HOWARD, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/59	22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	22d. LOCATION (City, town, or county) Centreville, Maryland	(State)
-----------------------------------------------------	------------------------------	-------------------------------------------------------------	----------------------------------------------------------------	---------

23 FUNERAL DIRECTOR'S SIGNATURE <i>James B. Daniels</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 20 '59	24b REGISTRAR'S SIGNATURE <i>Arthur J. Evans</i>
------------------------------------------------------------	---------	--------------------------------------------	-----------------------------------------------------

James B. Dashiell

Laston, Maryland



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL (SPARKS, MD.)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SPARKS, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Dudley, Jr. C Babb		4. DATE OF DEATH Mar 7 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1938
9. AGE (In years last birthday) 21 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U S	
13. FATHER'S NAME DUDLEY C. BABB		14. MOTHER'S MAIDEN NAME MARGARETTA LACKEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 214-40-6676	
17. INFORMANT DUDLEY C. BABB		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 910.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 15 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Ground caved in & covered him with dirt	
20c. TIME OF INJURY Month, Day, Year 3 3 p.m. MAR 4 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 111		20f. (City or town) (County) (State) West SPARKS BALTO. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. M. France		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) A. M. FRANCE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-7-1959	
22c. NAME OF CEMETERY OR CREMATORY GUNPOWDER MEETING HOUSE CEM.		22d. LOCATION (City, town, or county) (State) BALTO Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. JENKINS & SONS Co		24a. REC'D BY REGISTRAR DATE MAR 9 1959	
ADDRESS 4905 YORK RD BALTO, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. French	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2733

CERTIFICATE OF DEATH

02701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 28yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 138 N Patterson Ave.			
3. NAME OF DECEASED (Type or print) First McKinley Middle Neal Last Barkley				4. DATE OF DEATH Month March Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-01	
9. AGE (In years first birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME F.H. Barkley				14. MOTHER'S MAIDEN NAME Clara Mehrmann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Bilateral lobar pneumonia							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1958 to Mar. 15, 1959 , that I last saw the deceased alive on Mar. 15, 1959 , and that death occurred at 10:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James Donald Drinkard				M.D. Spring Grove State Hospital		DATE SIGNED 3-15-59	
NAME (Type) James Donald Drinkard, M.D.				Spring Grove State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/18/59		22b. DATE THEREOF 3/18/59		22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Lusby Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Kuch				ADDRESS 305 Maryland		24a. REC'D BY REGISTRAR DATE MAR 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

02702

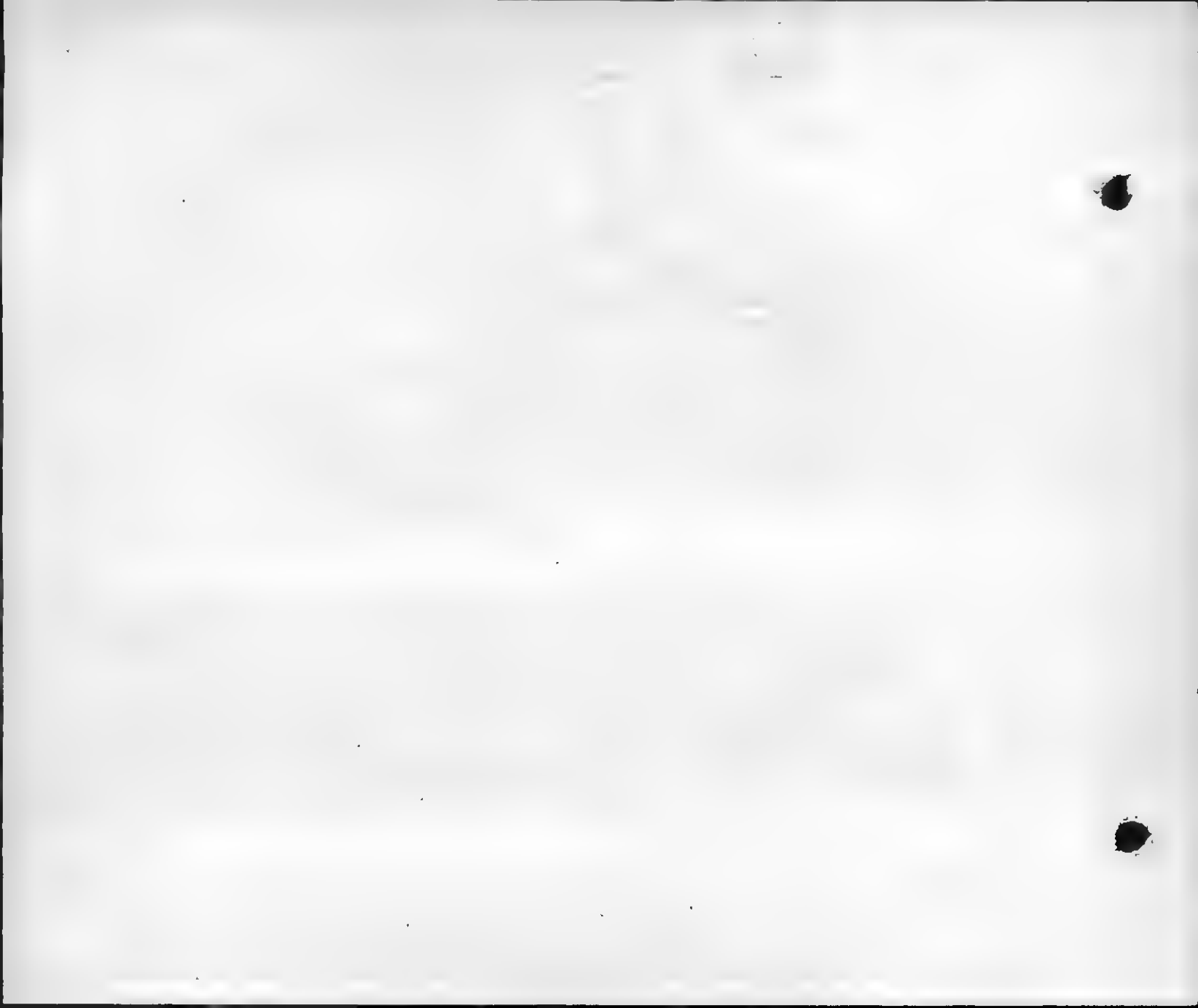
Reg. Dist. No.

2712

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>APR 50705</u>		c. LENGTH OF STAY IN 1b <u>34 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3505 GEORGETOWN RD</u>		e. STREET ADDRESS <u>13505 GEORGETOWN RD</u>	
3. NAME OF DECEASED (Type or print) First <u>GLEO</u> Middle <u>P. BARNETT</u> Last <u>P. BARNETT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 JAN 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>SV VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRESLEY JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>RIFLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>JOHN W. BARNETT</u>		Address <u>3505 Georgetown Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 4. " " DUE TO <u>myocardosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <u>status post stroke</u> (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1955</u> to <u>March 1959</u> , that I last saw the deceased alive on <u>3/1/59</u> , 19 <u> </u> , and that death occurred at <u>7:20</u> A.M. from the causes and on the date stated above			
ACTUAL <u>Henry Armanas</u> M.D.		ADDRESS (Street, city or town, state) <u>1934 Wilkens Ave Baltimore, Md</u>	
PHYSICIAN'S NAME (Type) <u>HENRY ARMANAS</u>		DATE SIGNED <u>3/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CLAIR</u>	22b. DATE THEREOF <u>March 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McANNISKUN Cem</u>	22d. LOCATION (City, town, or county) (State) <u>WESTON VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Youlson</u>		ADDRESS <u>7359 Wash Blvd</u>	
24a. REC'D BY REGISTRAR <u>MAR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2734

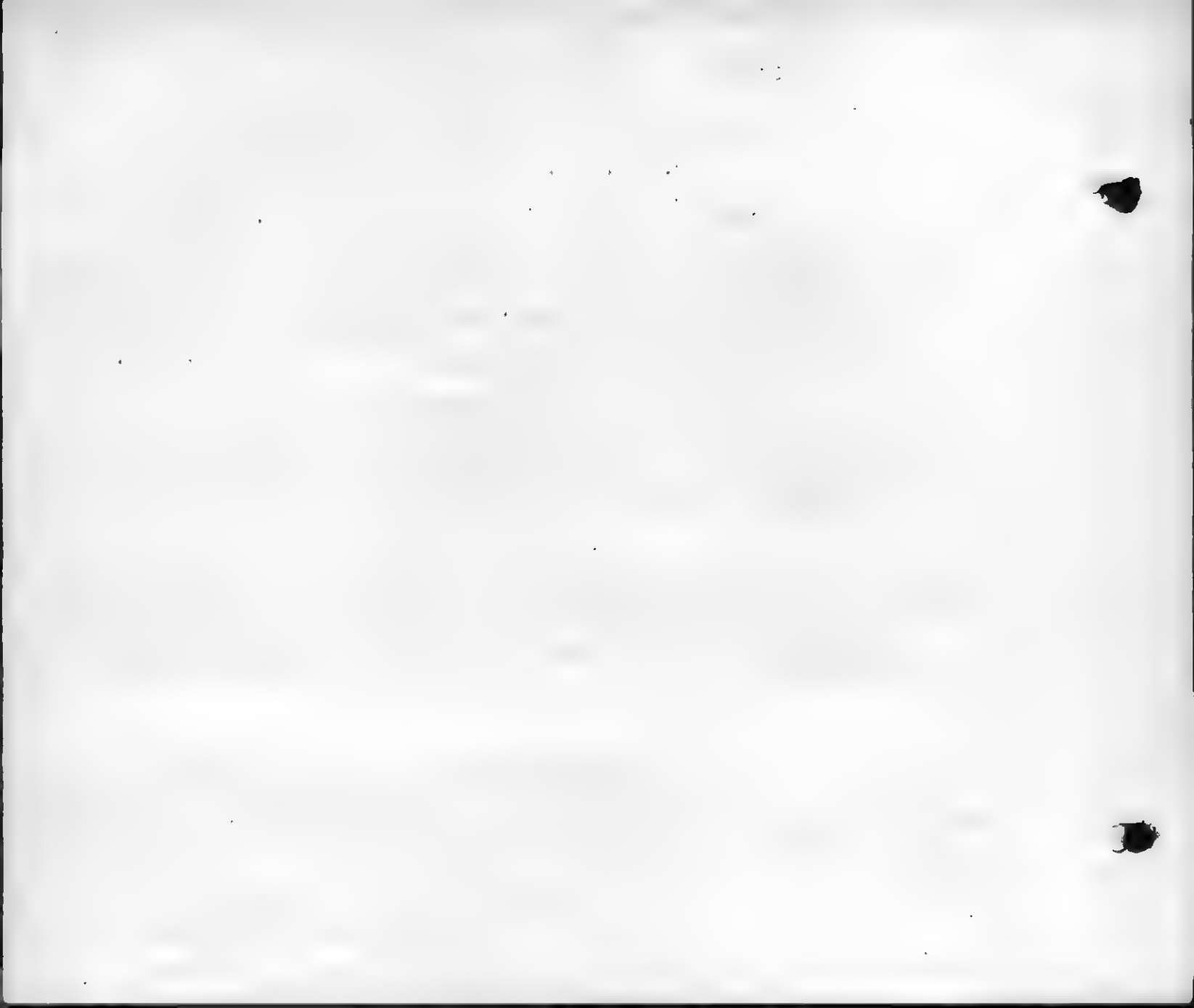
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Harford County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 8yr. 11mo. 29da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard & Enoch Pratt Hospital, Towson 4, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
3 NAME OF DECEASED (Type or print) First May Middle Cochran Last Bay		4. DATE OF DEATH Month March Day 16 Year 1959	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1877
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Register Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Cochran		14. MOTHER'S MAIDEN NAME Mary Stephenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO —	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar pneumonia 422.1 DUE TO (b) Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3da. 10yr + " "
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Synchome			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 17, 1959 to March 16, 1959 , that I last saw the deceased alive on March 14, 1959 , and that death occurred at 4:15 AM , from the causes and on the date stated above.			
SIGNATURE W.W. Elgin		ADDRESS (Street, city or town, state) Sheppard Pratt Hosp. 3/16/59	
PHYSICIAN'S NAME (Type) W.W. Elgin		DATE SIGNED 3/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Angel Hill Cem		22d. LOCATION (City, town, or county) (State) Havre de Grace Md.	
23. FUNERAL DIRECTOR'S SIGNATURE K. Hurdson Mitchell		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR MAR 19 1959		24b. REGISTRAR'S SIGNATURE Arthur E. Hana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2735

CERTIFICATE OF DEATH

02704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 4 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland d. STREET ADDRESS 7008 Emerson Street e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jeanette Middle Gay Last Becker		4. DATE OF DEATH Month 3 Day 12 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/53 9. AGE (In years last birthday) 5 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Augustine Becker		14. MOTHER'S MAIDEN NAME Harriett Barton Post	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO —	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Hydrocephalus, marked 14X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on autopsy , 19____, and that death occurred at 2:45 a.m. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 4307 Rainfield Ave DATE SIGNED 3/12/59			
ACTUAL SIGNATURE Peter W. Rieckert		PHYSICIAN'S NAME (Type) Peter W. Rieckert Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 16/59	22c. NAME OF CEMETERY OR CREMATORY Rosewood	22d. LOCATION (City, town, or county) (State) Baltimore Co Md
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Elmer, Sons Rustonstown Md		24a. REC'D BY REGISTRAR MAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2736

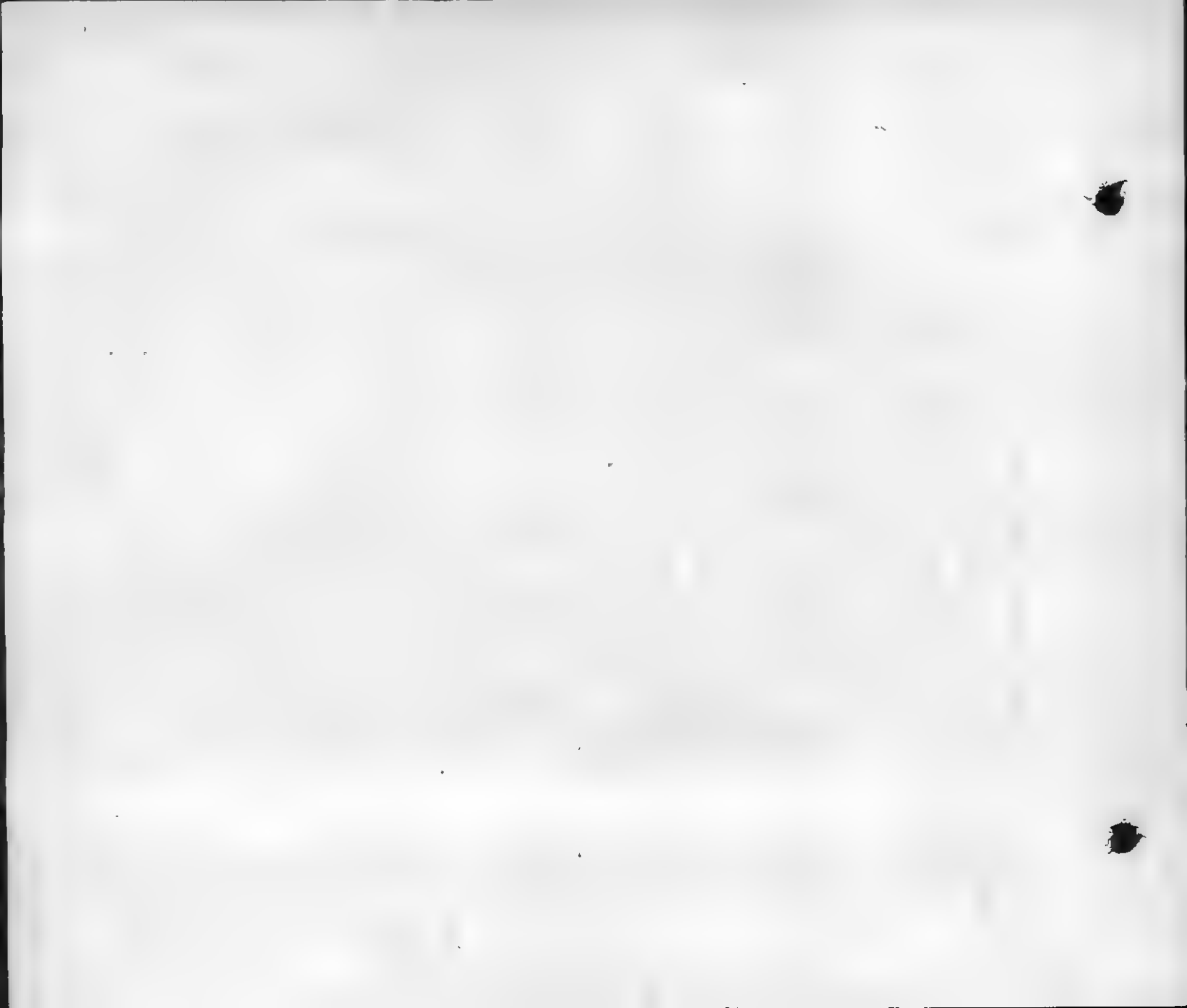
CERTIFICATE OF DEATH

02705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 8mths29dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 1228 Williams Street			
3. NAME OF DECEASED (Type or print) First Theresa Middle Last Beckert				4. DATE OF DEATH Month March Day 29 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Francis				14. MOTHER'S MAIDEN NAME Theresa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19, 1959 , to March 29, 1959 , that I last saw the deceased alive on March 29, 1959 , and that death occurred at 11:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-30-59							
ACTUAL SIGNATURE Stella Wachsler M.D.				PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/2/59		22c. NAME OF CEMETERY OR CREMATORY Halcyon Cross	
22d. LOCATION (City, town, or county) (State) Catonsville 28, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Toney & Sons				ADDRESS 1218 Light		24a. REC'D BY REGISTRAR DATE APR 2 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

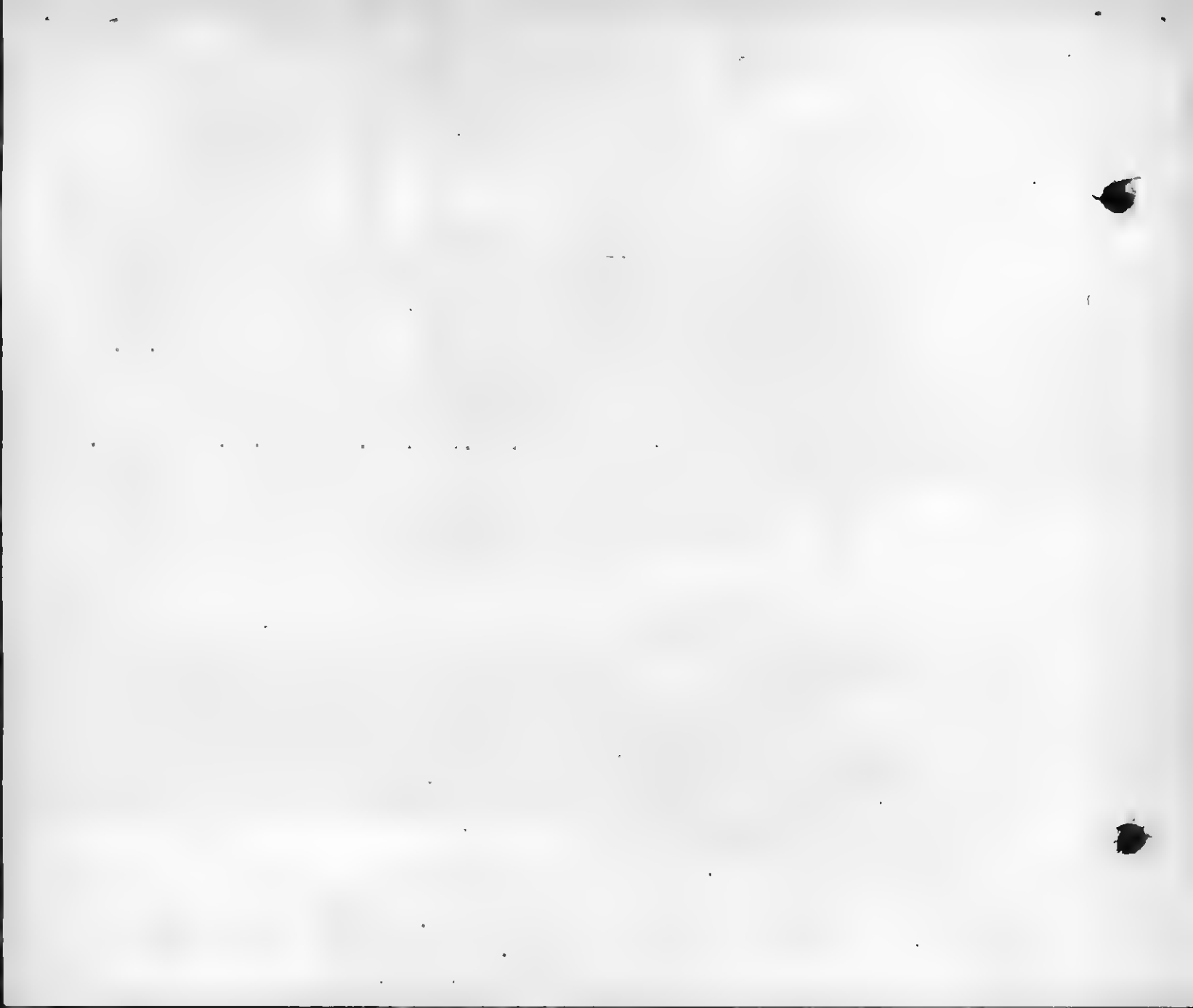
2737

CERTIFICATE OF DEATH

Reg. Dist. No.

02706

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 4303 Maine Avenue (7)			
3. NAME OF DECEASED (Type or print) First MANUEL Middle --- Last BERNSTEIN				4. DATE OF DEATH Month March Day 5 Year 1959			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH September 8, 1894		9 AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Barber - Retired			10b. KIND OF BUSINESS OR INDUSTRY Barber Shop		11 BIRTHPLACE (State or foreign country) Scotland		12 CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Samuel Bernstein				14. MOTHER'S MAIDEN NAME Bessie Lazeri			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16 SOCIAL SECURITY NO 215-14-5922		17 INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 Months 6 Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA, BILATERAL, BRONCHIAL						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 3 , 19 59 , to March 5 , 19 59 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 3/5/59 ACTUAL SIGNATURE I. Freeman M.D. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/59		22c. NAME OF CEMETERY OR CREMATORY Jewish War Veterans Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. ADDRESS 1126 W. North Ave. Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE C. J. & F. Hall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2738

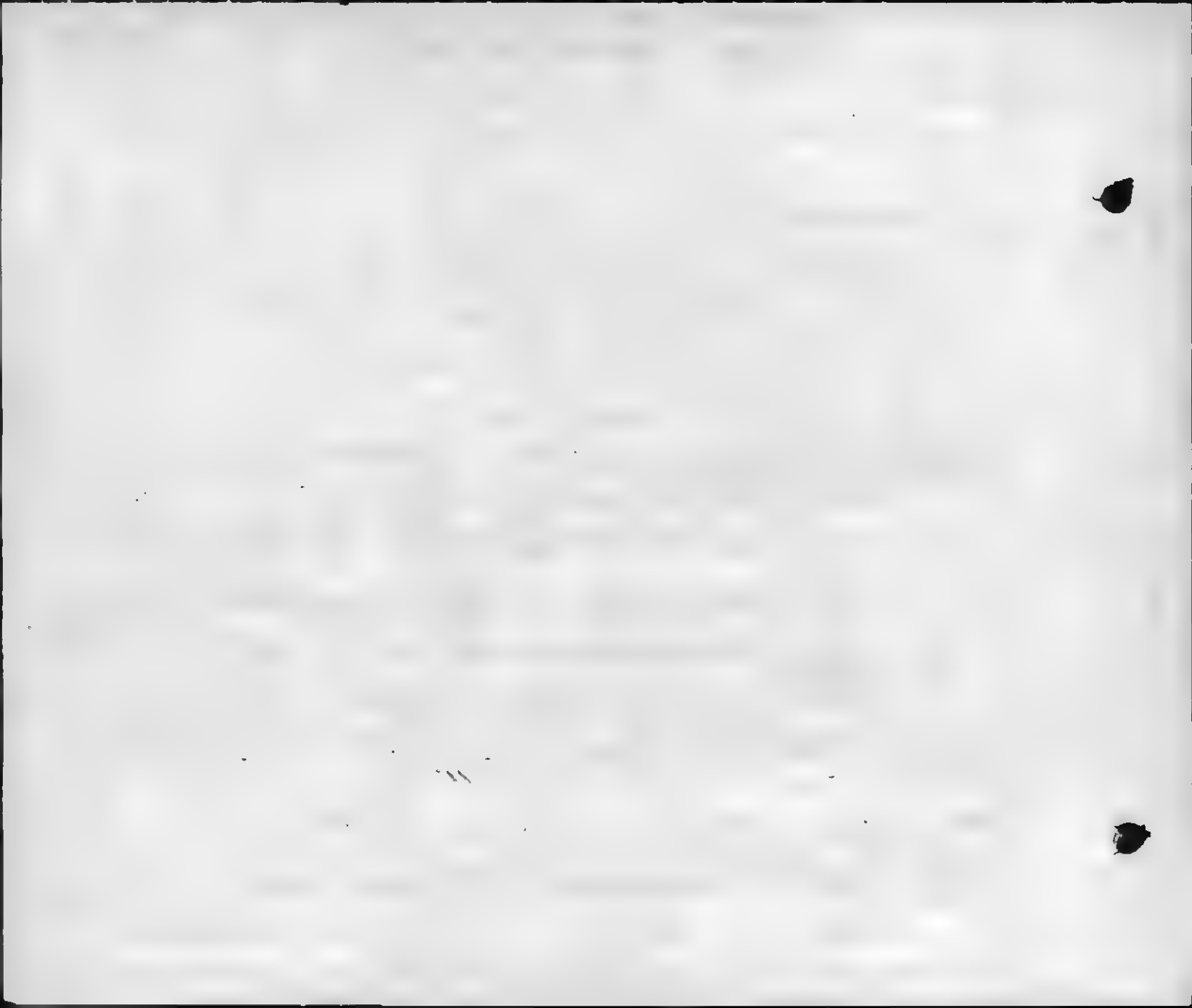
Item 9 3-18-59 et

CERTIFICATE OF DEATH

02707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>422 E. PA. AVE</u>				d. STREET ADDRESS <u>422 E. PA. AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E. N. BELLINGSLEY</u>				4. DATE OF DEATH Month Day Year <u>3 5 1959</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4. 1881</u>		9. AGE (In years last birthday) <u>77</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>CHAS SCOUENS</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA GRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>VERGENTIA FRAZIER</u>		17. INFORMANT Address <u>422 E. PA. AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>infarct of the cerebellum</u> DUE TO (c) <u>over 10 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1957</u> to <u>March 1959</u> that I last saw the deceased alive on <u>March 3</u> , 1959, and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Fowler</u>				ADDRESS (Street, city or town, state) <u>1707 North Enoch Ave. Lutherville 3rd St</u>			
DATE SIGNED <u>March 3 1959</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Schatman</u>				ADDRESS <u>1701 Mt. Calhoun St</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02708

2739

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write P.O.A. and give nearest town) Catonsville		c. LENGTH OF STAY IN I.B. 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. STREET ADDRESS 5603 Mattfeldt Ave. # 9	
3. NAME OF DECEASED (Type or print) William Joseph Bitterman		4. DATE OF DEATH Month March Day 21 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY TOOL MAKER	9. AGE (In years last birthday) 83 yrs
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus Bitterman		14. MOTHER'S MAIDEN NAME Louise McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO SERVICE		16. SOCIAL SECURITY NO 214-01-4485	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Heart Condition			
(b) Heart Condition DUE TO Heart Condition			
(c) Heart Condition DUE TO Heart Condition			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Stewart & Mowen M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Stewart & Mowen		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Mar 21 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 24, 1959	22c. NAME OF CEMETERY OR CREMATORY Stone Valley Cemetery	22d. LOCATION (City, town, or county) (State) Dalmatia, Northumberland Co., Pa.
23. FUNERAL DIRECTOR'S SIGNATURE STEWART & MOWEN COMPANY 108 W. North Av. Balto.		24a. REC'D BY REGISTRAR MAR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-10. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02709

2740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Trenton Road		d. STREET ADDRESS Trenton Road	
3. NAME OF DECEASED (Type or print) Leeonie Blackwell		4. DATE OF DEATH March 14, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1896
9. AGE (In years and birthday) 63 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 249-12-5525	
17. INFORMANT Henry C. Blackwell, Upperco, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 45 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) none
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 17, 1959	
22c. NAME OF CEMETERY OR CREMATORY Memorial		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton, Hampstead, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral home. If the funeral home is not the place of burial, cremation, or removal, give the certificate to the funeral home. If the funeral home is the place of burial, cremation, or removal, give the certificate to the funeral home. If the funeral home is the place of burial, cremation, or removal, give the certificate to the funeral home.



2741

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Lee</u> Last <u>Bootman</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W Sewing factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash shirts</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery County</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Elmer Smith</u>		14. MOTHER'S MAIDEN NAME <u>Leanna H. Hubbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>214-22-0410</u>	
17. INFORMANT <u>Ethel Mansfield</u>		Address <u>101 Clarendon Av.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 1950, to <u>March 13</u> , 1959, that I last saw the deceased alive on <u>March 12</u> , 1959, and that death occurred at <u>9:20 A</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D. <u>1632 Reisters Town Road</u> PHYSICIAN'S NAME (Type) <u>Charles H. Williams, M.D.</u> <u>Pikesville 8</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVA, (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March</u>	<u>Long Hill Cemetery</u>	<u>Tunnel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Newell</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
ADDRESS <u>Pikesville 8, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2742

CERTIFICATE OF DEATH

Reg. Dist. No.

02719

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randelstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7200 Dianna Place				d. STREET ADDRESS 7200 Dianna Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adolph Middle F. Last Bornscheuer				4. DATE OF DEATH Month March Day 24 Year 1959			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/83		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic (retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Baltimore Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Bornscheuer				14. MOTHER'S MAIDEN NAME Louisa Kalb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO unknown		17. INFORMANT Address Elizabeth L. Bornscheuer 7200 Dianna Pl.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction acute DUE TO Anteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) secondary. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Instantaneous
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis 2X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 March, 1959 to 24 March, 1959 , that I last saw the deceased alive on 24 March, 1959 , and that death occurred at 7:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6512 Liberty Road DATE SIGNED							
ACTUAL SIGNATURE Marvin H. Davis M. D.				ADDRESS (Street, city or town, state) 6512 Liberty Road			
PHYSICIAN'S NAME (Type) MARVIN H. DAVIS				Baltimore 7, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran ADDRESS 3000 E. Baltimore St. Balto. Md.				24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02712

2743

1. PLACE OF DEATH a. COUNTY Baltimore		b. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington		c. LENGTH OF STAY IN lb 5 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Mt. Washington			
d. NAME OF HOSPITAL (If not in hospital give street address) 2108 Smith Ave.				d. STREET ADDRESS 2108 Smith Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Elizabeth				First Bostwick		Last	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 5-1878	
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.		10. AGE (In years last birthday) 80		IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Elkridge, Howard Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Kibbey				14. MOTHER'S MAIDEN NAME ELIZA WELLS.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT Ellen Kibbie Shaneybrook, 2108 Smith Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 26, 1955 to March 30, 1959 , that I last saw the deceased alive on March 30, 1959 and that death occurred at P.P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Miller		M.D.		ADDRESS (Street, city or town, state) 1331 Reisterstown Rd. Pikesville, Md.		DATE SIGNED 4/1/59.	
PHYSICIAN'S NAME (Type) Dr. James H. Miller							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-2-59		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.				ADDRESS Pikesville, Md.		24a. REC'D BY REGISTRAR DATE APR 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 02717

2744

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUXTON		c. LENGTH OF STAY IN lb 6 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RUXWAY MANOR HOME.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JANE E. BOTELER		4. DATE OF DEATH Month Day Year 3 - 7 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-78
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT CHARLES A. WHITEFORD		Address 3705 ELM AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO is possible dysfunction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) stroke related heart disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct , 19 58 to March 7 , 19 59 , that I last saw the deceased alive on March 7 , 19 59 , and that death occurred at 4:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul E. Chenoweth		ADDRESS (Street, city or town, state) DATE SIGNED 15 E BIDDLE ST BALTO 3/4/59	
PHYSICIAN'S NAME (Type) F.M. DUGAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-10-59	22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	22d. LOCATION (City, town, or county) (State) BALTO.
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenoweth		ADDRESS 3617 Chestnut Ave	
24a. REC'D BY REGISTRAR DATE MAR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

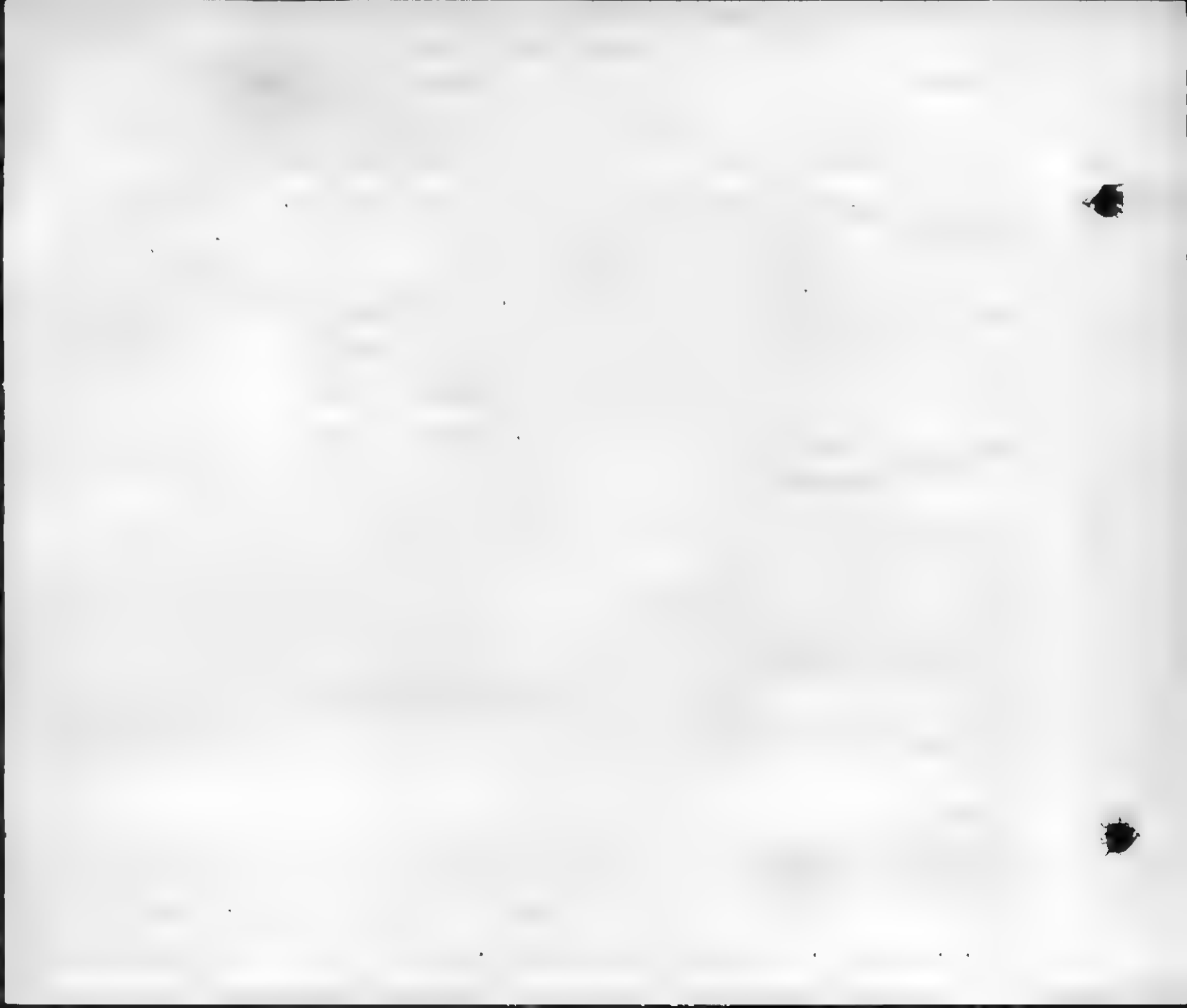
2745 CERTIFICATE OF DEATH

02714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>418 Grovethorn Road</u>				d. STREET ADDRESS <u>418 Groverthorn Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>Bowes</u> Last				4. DATE OF DEATH <u>3</u> Month - <u>17</u> Day 19 <u>59</u> Year			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 24, 1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Miller</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Askey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs. Cynthia Shaw,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>502X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>22 2.2 1959</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>11:00</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11:00</u> 19 <u>59</u> , to <u>11:00</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3/17/59</u> , 19 <u>59</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>805 FUGLE CR</u> DATE SIGNED <u>3/20/59</u>							
ACTUAL SIGNATURE <u>Joseph J. Ruck, Inc.</u> M.D.				NAME (Type) <u>SPEAR MU</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clearfield, Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck, Inc. 5305 Harford Rd. Balto 14</u> ADDRESS				24a. REC'D BY REGISTRAR <u>MAR 19 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be filled out within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2746

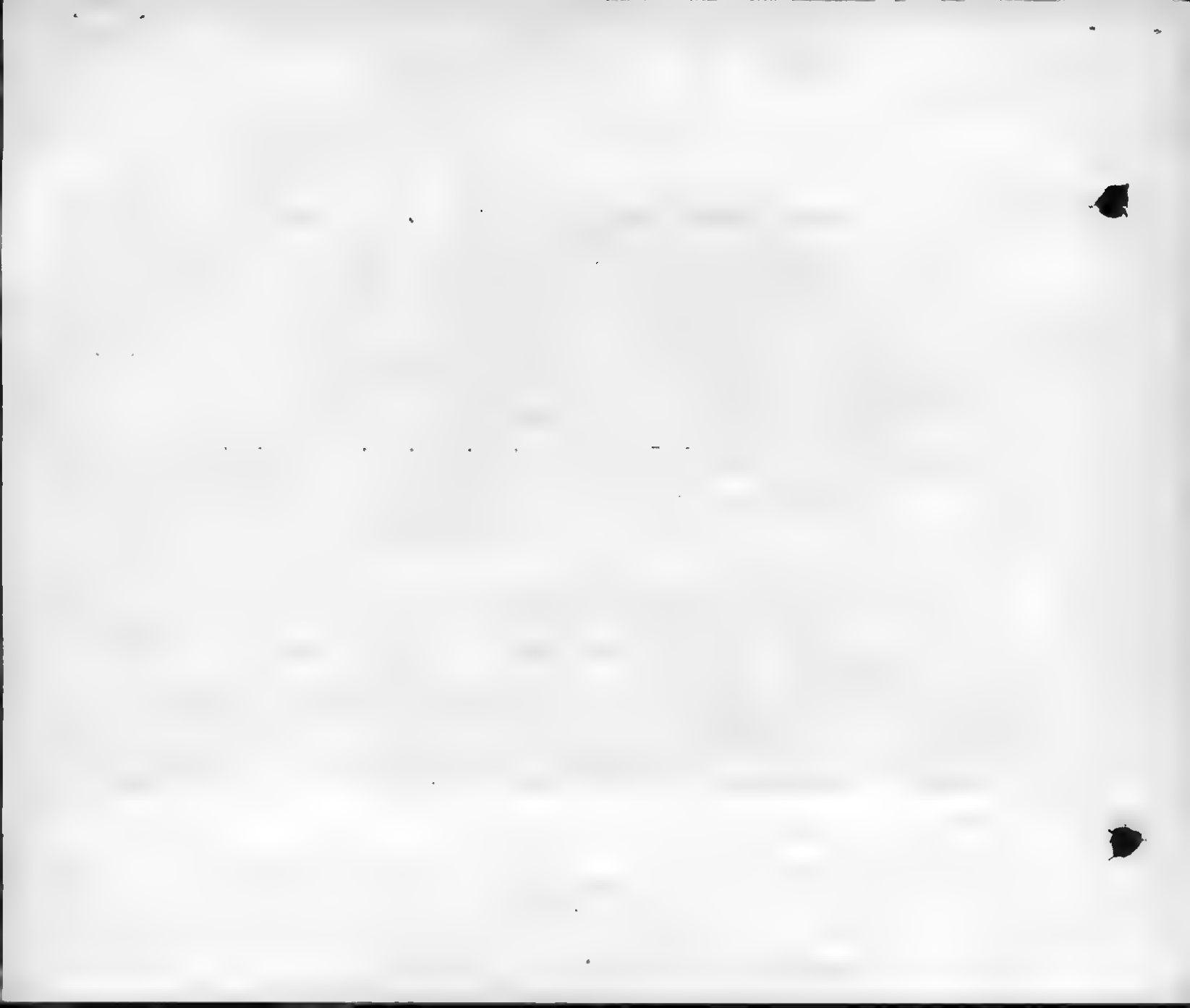
CERTIFICATE OF DEATH

02715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore (5)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1835 E. Eager Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM H. BRADFORD		4. DATE OF DEATH Month Day Year March 11 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Furniture Warehouse)	
11. BIRTHPLACE (State or foreign country) Port Deposit, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lewis Bradford		14. MOTHER'S MAIDEN NAME Josephine Ringgold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-18-5241	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PYELONEPHRITIS		INTERVAL BETWEEN ONSET AND DEATH 6 Days 7 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 1959 to March 11, 1959 and that death occurred at 8:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/12/59			
ACTUAL SIGNATURE John W. Crawford M.D.			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, FORT HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR 1959 DATE	
24b. REGISTRAR'S SIGNATURE 18			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02716

2747

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Hanover Road		d. STREET ADDRESS Old Hanover Road	
3. NAME OF DECEASED (Type or print) Lon Russell Breeden		4. DATE OF DEATH March 28, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1891
9. AGE (in years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 20 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance at High School		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin Breeden		14. MOTHER'S MAIDEN NAME Elizabeth Comer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 219-12-8232	
17. INFORMANT Mrs. Sarah L. Breeden		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4.20.1 Coronary Occlusion		5 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fighting Field Fire.		20 min.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Was fighting field fire & dropped dead.	
20c. TIME OF INJURY Month, Day, Year Mar 28 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Reisterstown Balto Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		DATE SIGNED 3-30-59	
EXAMINER'S NAME (Type) D. D. CAPLES, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 31, 1959	22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial	22d. LOCATION (City, town, or county) Finksburg, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR APR 1 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2748

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. LENGTH OF STAY IN 1b <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven Nursing Home</i>				d STREET ADDRESS <i>106 Wiltshire Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John First Martin Middle Brendel Last</i>				4. DATE OF DEATH Month <i>3/</i> Day <i>10/</i> Year <i>19 59</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 4, 1890</i>		9. AGE (In years lost birthday) yrs. <i>69</i>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <i>Retired Davidson Chemical</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Chemical</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Brendel</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Herold</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-07-4998</i>		17. INFORMANT <i>Evelyn K. Wheeler</i>		Address <i>-106 Wiltshire Road #21</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>HEART SCENARIO CARDIAC</i> DUE TO <i>VASCULAR DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>PULMONARY EDEMA</i> DUE TO (c) <i>PNEUMONIA</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/11, 1909</i> to <i>3/10, 1959</i> , that I last saw the deceased alive on <i>3/10, 1959</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John D. Shaw</i> M.D. <i>520 E. Hammond Ave 3/14/59</i> PHYSICIAN'S NAME (Type) <i>John D. Shaw M.D.</i> <i>GRATE 28-1110</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/13/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 16 59</i>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2749

CERTIFICATE OF DEATH

02718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>SVC.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES HOME</u>				d. STREET ADDRESS <u>4735 DARTFORD AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E. BRENNAN</u>				4. DATE OF DEATH Month Day Year <u>MARCH 4, 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 2, 1903</u>	
9. AGE (In years last birthday) yrs <u>56</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM LEVDNAS</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address (29) <u>MRS. CURA KERNAN 4735 DARTFORD AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous General (Especially)</u> <u>154X</u> DUE TO <u>Carcinoma of Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>54</u> to <u>Mar 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 4</u> , 19 <u>59</u> , and that death occurred at <u>9:30 A.</u> M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Charles A. Cahn</u> M.D. <u>2145 N. Baltimore St</u>				DATE SIGNED <u>3/4/59</u>			
PHYSICIAN'S NAME (Type) <u>Charles A. Cahn</u>				<u>Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/6/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>				ADDRESS <u>3512 Frederick Ave. (29)</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>							



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 10 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 MURDOCK ROAD		e. STREET ADDRESS 525 MURDOCK ROAD	
3. NAME OF DECEASED (Type or print) AGNES M. BUDDEMEIER		4. DATE OF DEATH March 16 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 8, 1885
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. B. MOONEY		14. MOTHER'S MAIDEN NAME MARY ANN SHANNON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-20-7984	
17. INFORMANT HENRY W. BUDDEMEIER		Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. C'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. C'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Spec. f.) BURIAL	22b. DATE THEREOF 3-14-59	22c. NAME OF CEMETERY OR CREMATORY PARKWOOD	22d. LOCATION (City, town, or county) (State) BALTO. Co MD
23. FUNERAL DIRECTOR'S SIGNATURE H. W. JENKINS & SONS Co. 4905 YORK ROAD		24a. REC'D BY REGISTRAR MAR 11 1959 DATE	
		24b. REGISTRAR'S SIGNATURE William S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-13. Pages 1, 2, and 3 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.



2751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
				d. STREET ADDRESS 15 Dutton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annabelle Middle Bunnell Last				4. DATE OF DEATH Month March Day 11 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1872		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Marshall Doyl				14. MOTHER'S MAIDEN NAME Virginia Biscoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Gathwright 101 Oakdale Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Decubitus ulcers Buttocks; Draining perirectal Abscess			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) July 58		20f. (City or town) (County) (State) 3/11/59	
21. I certify that I attended the deceased from July 58 to 3/11/59 , that I last saw the deceased alive on 3/10/59 and that death occurred at 4:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.E. McGrath				M.D. 1303 Frederick Rd		DATE SIGNED 3/13/59	
PHYSICIAN'S NAME (Type) W.E. McGrath				Catonsville Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woollawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harley P. Hall				ADDRESS 2000 Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

2752

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY B			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1mth3dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland			
f. STREET ADDRESS 1124 Sterret Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ezra Middle S. Last Burr				4. DATE OF DEATH Month March Day 9 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1878	
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Hardware Store			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO Unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cardiac decompensation DUE TO (c) Arteriosclerotic cardiovascular disease PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 6, 1959 , to March 9, 1959 , that I last saw the deceased alive on March 9, 1959 , and that death occurred at 12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-10-59							
ACTUAL SIGNATURE Stella Wachslar				M. D. SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3/13/59		Landon Park Cem.		3801 Frederick Ave.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Bowman				ADDRESS 3801 Frederick Ave.		24a. REC'D BY REGISTRAR DATE MAR 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02723

2753

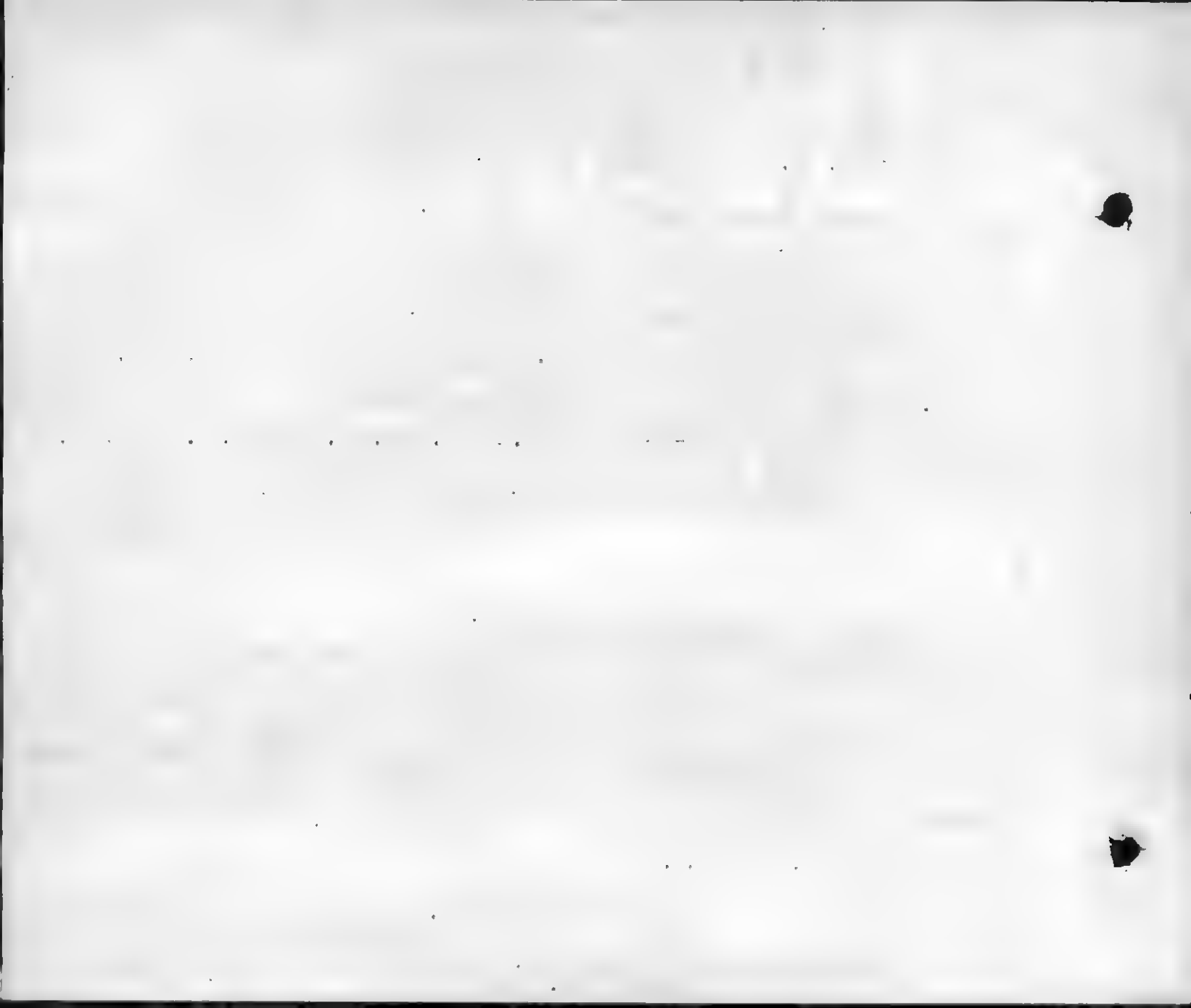
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN TB 5 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (11)		d. STREET ADDRESS 1008 W. 42nd Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last BURRELL		4. DATE OF DEATH Month March Day 19 Year 19 59	
5 SEX Male	6 COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 28, 1898
9 AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Construction Co., Gloucester, Virginia	
11 BIRTHPLACE (State or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME John T. Burrell		14. MOTHER'S MAIDEN NAME Eloise Johnson	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO 217-05-5448	
17 INFORMANT Clin. Ex Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RECURRENT GASTRIC CARCINOMA WITH METASTASIS TO LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrectomy and Jejunosomy-Operations 5/1/58		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14, 1959 to March 19, 1959 and that death occurred at 3:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald D. Mark</i>		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.		DATE SIGNED 3/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/21/59	
22c. NAME OF CEMETERY OR CREMATORY Gloucester Field Cem.		22d. LOCATION (City, town, or county) (State) Gloucester County, Virginia	
23 FUNERAL DIRECTOR'S SIGNATURE NUTTER'S FUNERAL SERVICE, 3004 Clifton Ave.		ADDRESS Balto 16, Md.	
24a. REC'D BY REGISTRAR MAR 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.




MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02723

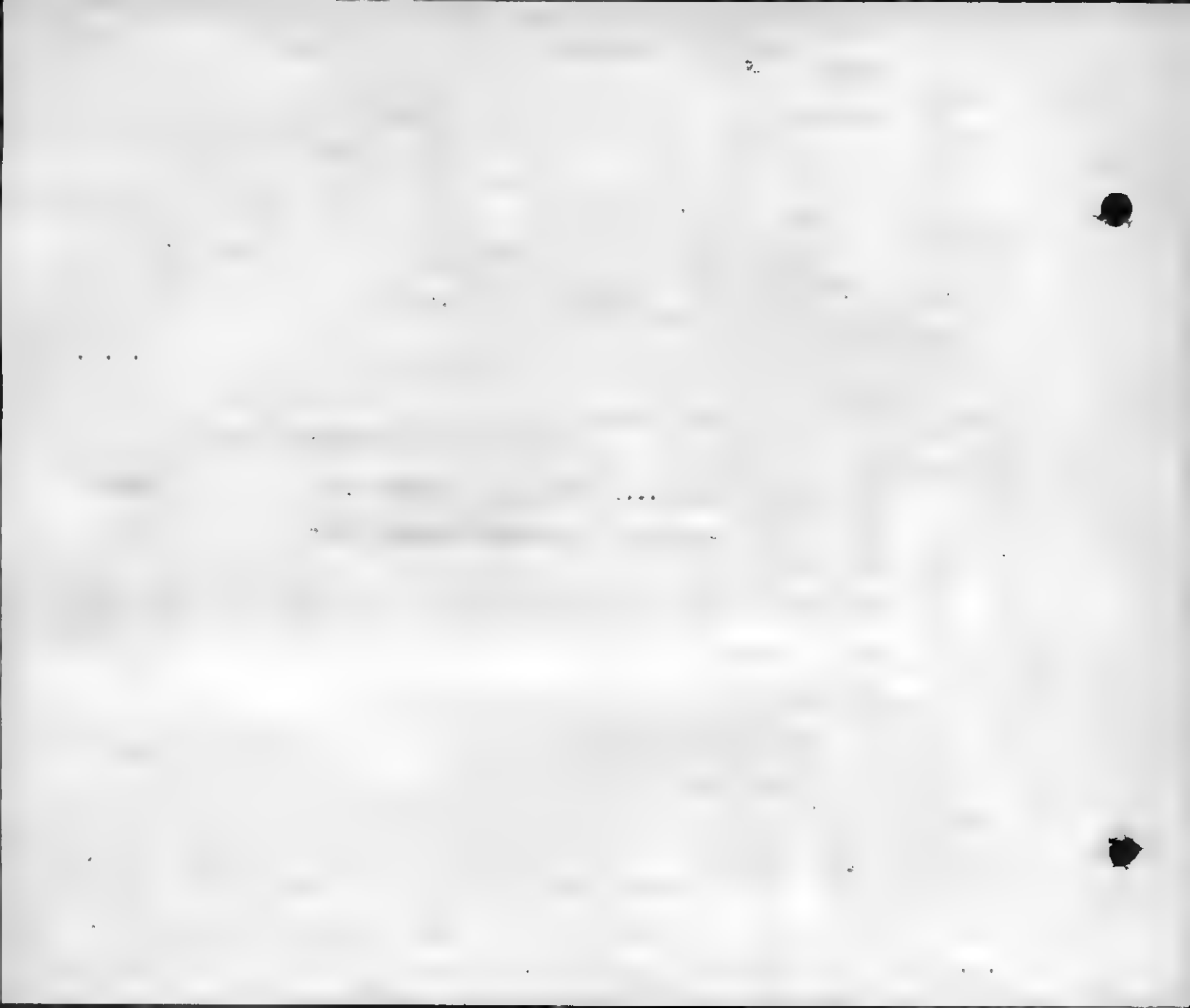
Reg. Dist. No.

2754

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8419 Loch Raven Blvd.				d. STREET ADDRESS 8419 D LOCHRAVEN BLVD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FANNIE Middle I Last BUSCHARDT				4. DATE OF DEATH Month March Day 7 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1868		9. AGE (in years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hamilton Riall				14. MOTHER'S MAIDEN NAME Rose Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Helen Brown (daughter) same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE...Cerebral Artery Hemorrhage DUE TO (b) Generalized advanced Atherosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH approx 1 hr undet	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
27. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John C Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto		24a. REC'D BY REGISTRAR MAR 9 '59	
				24b. REGISTRAR'S SIGNATURE Cirking S. Hume			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.



02724

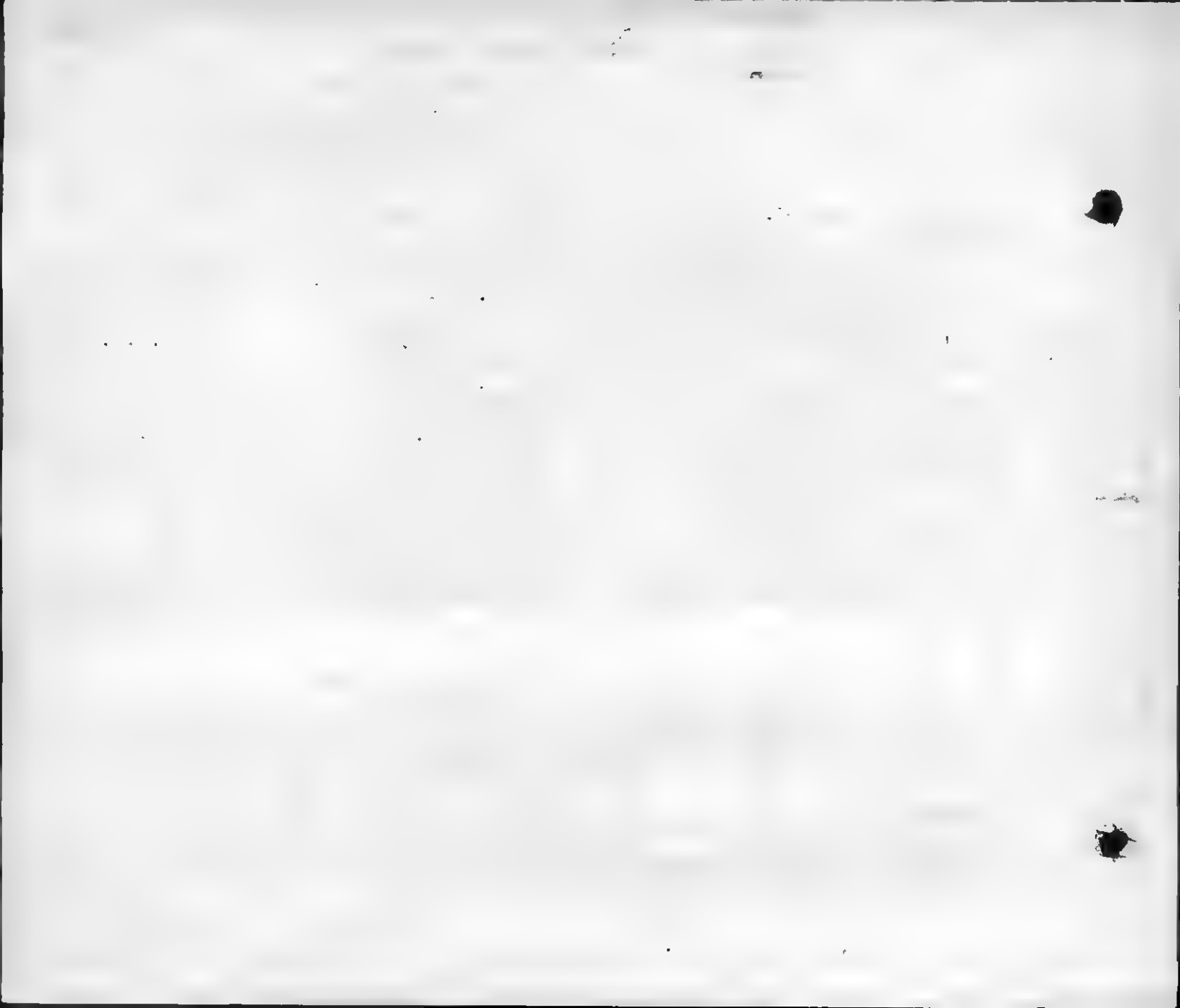
2755
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Lutherville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1404 Alston Court				e. STREET ADDRESS 1404 Alston Court			
3. NAME OF DECEASED (Type or print) First Robert Middle M. Last Byrd				4. DATE OF DEATH Month March Day 23 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1896	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 1 Days 4 Hours 1 Min.	IF UNDER 24 HRS. Months 1 Days 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Printer		10b. KIND OF BUSINESS OR INDUSTRY Arthur Thompson Company		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Byrd				14. MOTHER'S MAIDEN NAME Emma Mueller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO 216-07-8433		17. INFORMANT Mrs. Marie A. Byrd , Address 1404 Alston Court, Lutherville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 15, 1958 to March 25, 1959 that I last saw the deceased alive on March 23, 1959 and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville, Md DATE SIGNED 3/25/59							
ACTUAL SIGNATURE George I. Gilmore, MD		PHYSICIAN'S NAME (Type) GEORGE I. GILMORE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-27-59		22c. NAME OF CEMETERY OR CREMATORY Garden of Faith Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc, 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE MAR 30 59		24b. REGISTRAR'S SIGNATURE Charles E. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2756

CERTIFICATE OF DEATH

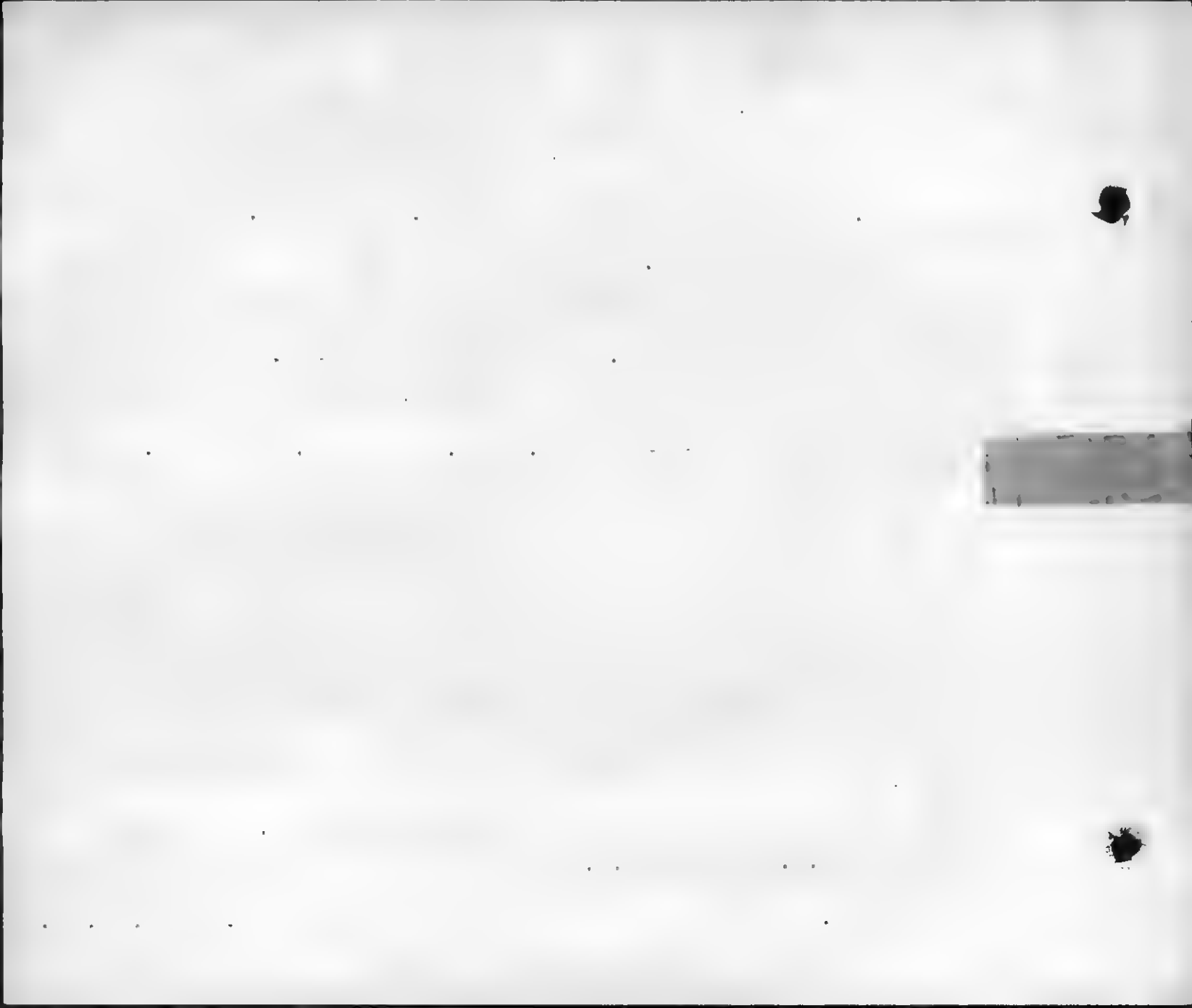
02757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut an Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN lb Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. Overlea Ave.		e. STREET ADDRESS W. Overlea Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last John L. Caples		4. DATE OF DEATH Month Day Year March 2, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1900
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Cab Co.	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Caples		14. MOTHER'S MAIDEN NAME Clara Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 212-16-5079	
17. INFORMANT Mrs. Ann J. Caples		Address 4 W. Overlea Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Previous coronary thrombosis (c) myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore		(County) (State)	
21. I certify that I attended the deceased from 4/23, 1947 to 3/2, 1959 , that I last saw the deceased alive on 2/16, 1959 , and that death occurred at 4 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 5829 Belair Rd. 3/4/59			
ACTUAL SIGNATURE D. T. Battaglia		M.D. 5829 Belair Rd.	
PHYSICIAN'S NAME (Type) D. T. Battaglia M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 6, 1959	
22c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		22d. LOCATION (City, town, or county) (State) Trump Will Rd. Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassaka Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR MAR 6 '59		24b. REGISTRAR'S SIGNATURE Clara S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

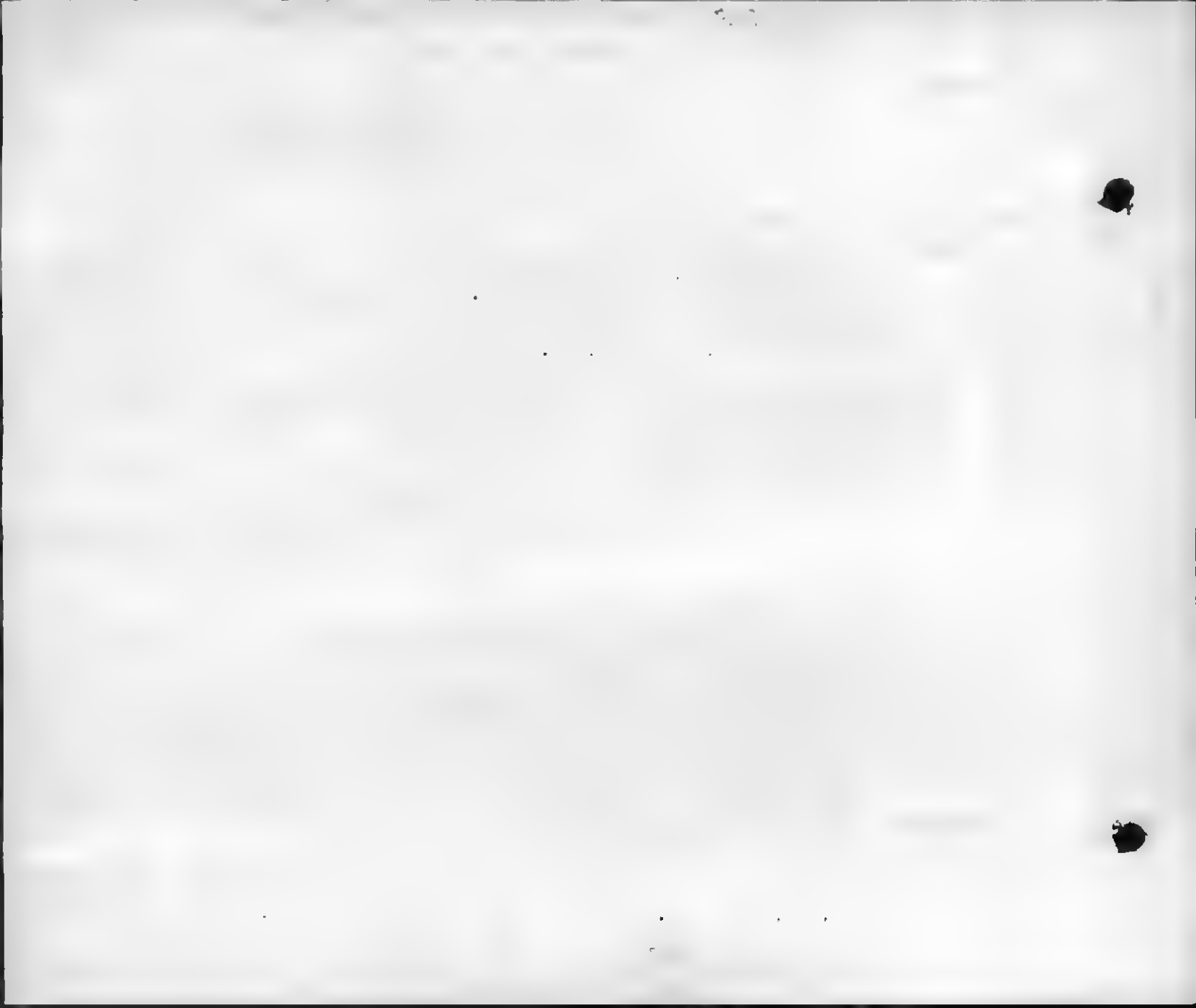
2757 CERTIFICATE OF DEATH

Reg. Dist. No.

12726

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin				c. LENGTH OF STAY IN 1b X Baldwin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leonard Middle Joseph Last Corman				4. DATE OF DEATH Month March Day 22 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1888	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-retired		10b. KIND OF BUSINESS OR INDUSTRY B. & D. Mfg. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Corman				14. MOTHER'S MAIDEN NAME Elizabeth Pearce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes WW I		16. SOCIAL SECURITY NO 216-03-9537		17. INFORMANT Family records			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic CVD DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary retention secondary to Cx Prostate						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Nov. 1958 to March 22, 1959 , that I last saw the deceased alive on March 22, 1959 , and that death occurred at 1:38 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Tyson M.D.		ADDRESS (Street, city or town, state) Kingsville Md.		DATE SIGNED 3-22-59			
PHYSICIAN'S NAME (Type) William A. Tyson							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY St. John's Catholic Cem.		22d. LOCATION (City, town, or county) (State) Long Green, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02727

2758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 20yr10mth27dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3716 Claremont Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Larry Middle Chiodo Last Chiodo		4. DATE OF DEATH Month Mar. Day 15 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21, 1907
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 15 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Chiodo		14. MOTHER'S MAIDEN NAME Carmella DEMASI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma, Lymphoblastic type DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 0 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 5 , 19 58 , to Mar. 15 , 19 59 , that I last saw the deceased alive on Mar. 15 , 19 59 , and that death occurred at 11 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE James Donald Drinkard M.D.		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-16-59	
PHYSICIAN'S NAME (Type) James Donald Drinkard, M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-19-59	22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.	22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD M.D.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Feiler		ADDRESS 901 S. CONKLING ST BALTO, MD	
24a. REC'D BY REGISTRAR APR 18 1959		24b. REGISTRAR'S SIGNATURE CHAS L FEILER	



2759

CERTIFICATE OF DEATH

02728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b X Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 130 Greenmeadow Drive		d. STREET ADDRESS 130 Greenmeadow Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IRBY Middle CICERO Last COLE, SR.		4. DATE OF DEATH Month March Day 5 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1901
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolphus H. Cole		14. MOTHER'S MAIDEN NAME Sarah Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 230-18-5249	
17. INFORMANT Mrs. Cecil M. Cole, 130 Greenmeadow Dr. Timonium		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Coronary Artery Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October, 1956 , to March 5th, 1959 , that I last saw the deceased alive on Feb. 17th, 1959 , and that death occurred at 9:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M. K. Quinn		ADDRESS (Street, city or town, state) DATE SIGNED 1927 York Rd, TIMONIUM 3/6/59	
PHYSICIAN'S NAME (Type) M. K. QUINN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/59	22c. NAME OF CEMETERY OR CREMATORY Fork M.E.	22d. LOCATION (City, town, or county) (State) Fork, Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson, Inc. Towson, Md.		24. REC'D BY REGISTRAR MAR 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Brand			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2760

CERTIFICATE OF DEATH

Reg. Dist. No.

02730

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admision) a. STATE Maryland b. COUNTY ()			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 40 Wengate Road				d. STREET ADDRESS 40 Wengate Road			
3. NAME OF DECEASED (Type or print) First KENNETH Middle CONN Last CONN				4. DATE OF DEATH Month March Day 24 Year 1959			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1910		9. AGE (In years last birthday) 49 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 9 Hours 49 Min 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) Uniontown, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Conn				14. MOTHER'S MAIDEN NAME Dorothy -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 210-09-1469		17. INFORMANT Mrs. Daphne Jean Conn-40 Wengate Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease with recent congestive heart failure DUE TO (c) over one year						INTERVAL BETWEEN ONSET AND DEATH few minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17 , 19 59 to March 24 , 19 59 , that I last saw the deceased alive on A.M. of 3/24 , 19 59 , and that death occurred at 11:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4215 Park Heights Ave. Balto. 15, Md. DATE SIGNED Arthur S. Kraus							
ACTUAL SIGNATURE Ataollah Golpira M.D.				PHYSICIAN'S NAME (Type) Ataollah Golpira, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/25/59		22c. NAME OF CEMETERY OR CREMATORY Smithfield, Pennsylvania		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner ADDRESS Balto - 17, Md.				24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2761

CERTIFICATE OF DEATH

Reg. Dist. No.

02731

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Birdwood Ave.		e. STREET ADDRESS 105 Birdwood Ave.	
3. NAME OF DECEASED (Type or print) First Josephine Middle Louise Last Cook		4. DATE OF DEATH Month March Day 27 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1930
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Augustus Hanfmann		14. MOTHER'S MAIDEN NAME Theresa Reinhardt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Miss Bertha Cook		Address 105 Birdwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Cardio-Vascular - Renal Disease DUE TO (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-29-59 , 1941, to 3-27-59 , that I last saw the deceased alive on 3-26-59 , 1959, and that death occurred at 9:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		DATE SIGNED 3-30-59	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		Baltimore-25, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-31-59	22c. NAME OF CEMETERY OR CREMATORY St. Rose's Cem.	22d. LOCATION (City, town, or county) (State) Clonier Md.
23. FUNERAL DIRECTOR'S SIGNATURE Forley Funeral Home - Catonsville, Md.		24a. REC'D BY REGISTRAR DATE APR 2 '59	
		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 2210 4-2-59 et

CERTIFICATE OF DEATH

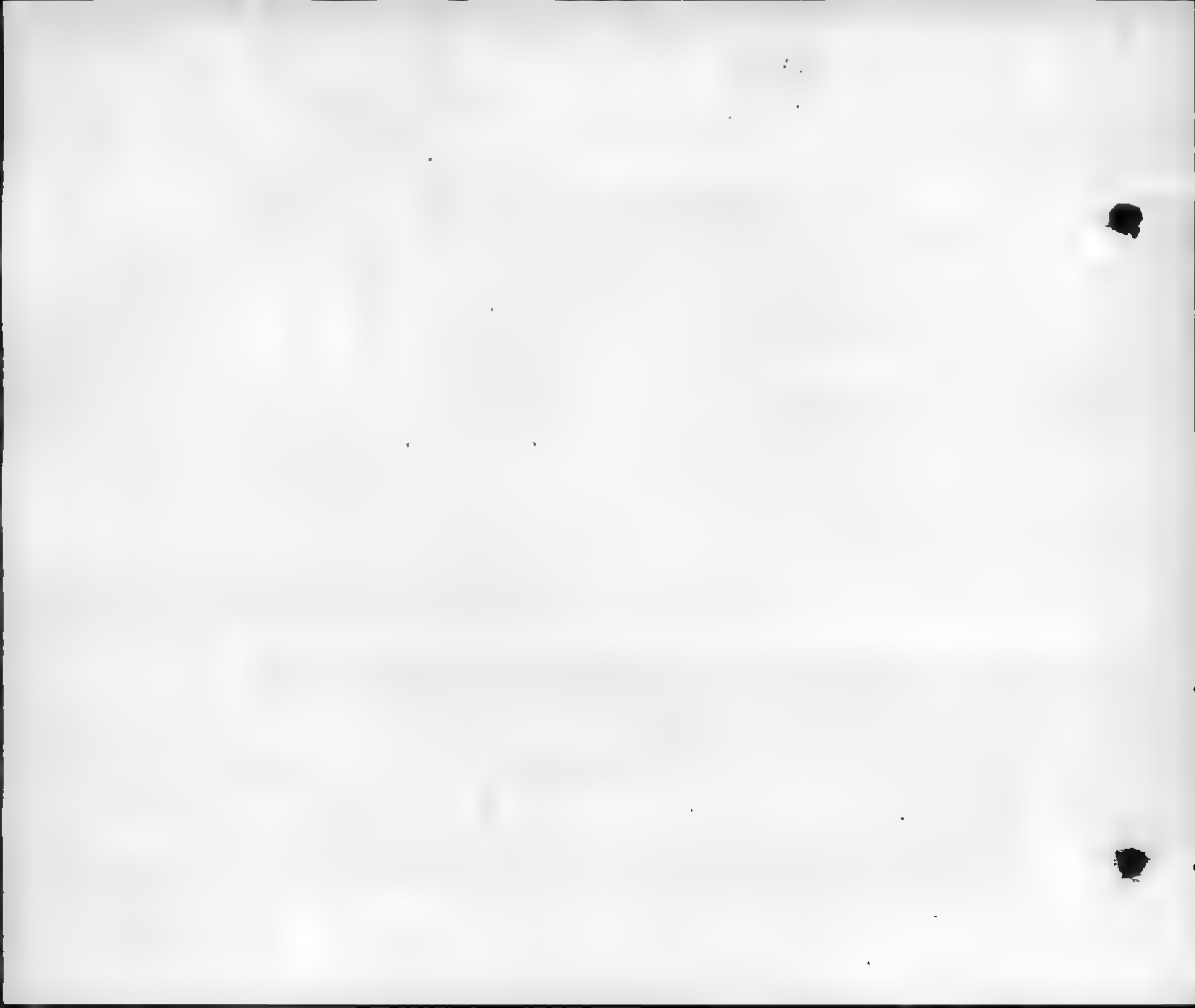
0273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lansdowne</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lansdowne</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2413 Brunswick Road</i>		d. STREET ADDRESS <i>2413 Brunswick Road</i>	
3. NAME OF DECEASED (Type or print) <i>Kate</i> First <i>Cordery</i> Middle Last		4. DATE OF DEATH <i>March 22 1959</i> Month Day Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 15, 1867</i>
9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>London, England</i>		12. CITIZEN OF WHAT COUNTRY? <i>England</i> ✓	
13. FATHER'S NAME <i>George Dicks</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mr. Frank C. Cordery,</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb. 2, 1959</i> to <i>March 22, 1959</i> , that I last saw the deceased alive on <i>March 21, 1959</i> , and that death occurred at <i>12:12 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Florian P. Nadolski</i> M.D.		DATE SIGNED <i>March 27, 1959</i>	
PHYSICIAN'S NAME (Type) <i>Florian P. Nadolski</i>		<i>Baltimore 27 Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/24/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>MAR 26 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

2762

02732

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yrl0mth29dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 11 Delano Drive - S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle Moore Last Couldren				4. DATE OF DEATH Month March Day 13 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1890 (?)		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jeffrey Moore				14. MOTHER'S MAIDEN NAME Mary Bowan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO 177-10-0312		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour 19 Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from March 7, 19 59 to March 13, 19 59 , that I last saw the deceased alive on March 13, 19 59 , and that death occurred at 10:55a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-13-59							
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL					
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-59		22c. NAME OF CEMETERY OR CREMATORY Millintown, Pa.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson, Inc. - Towson, Md.				ADDRESS 1050 York Rd.		24a. REC'D BY REGISTRAR DATE MAR 16 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02734

2714

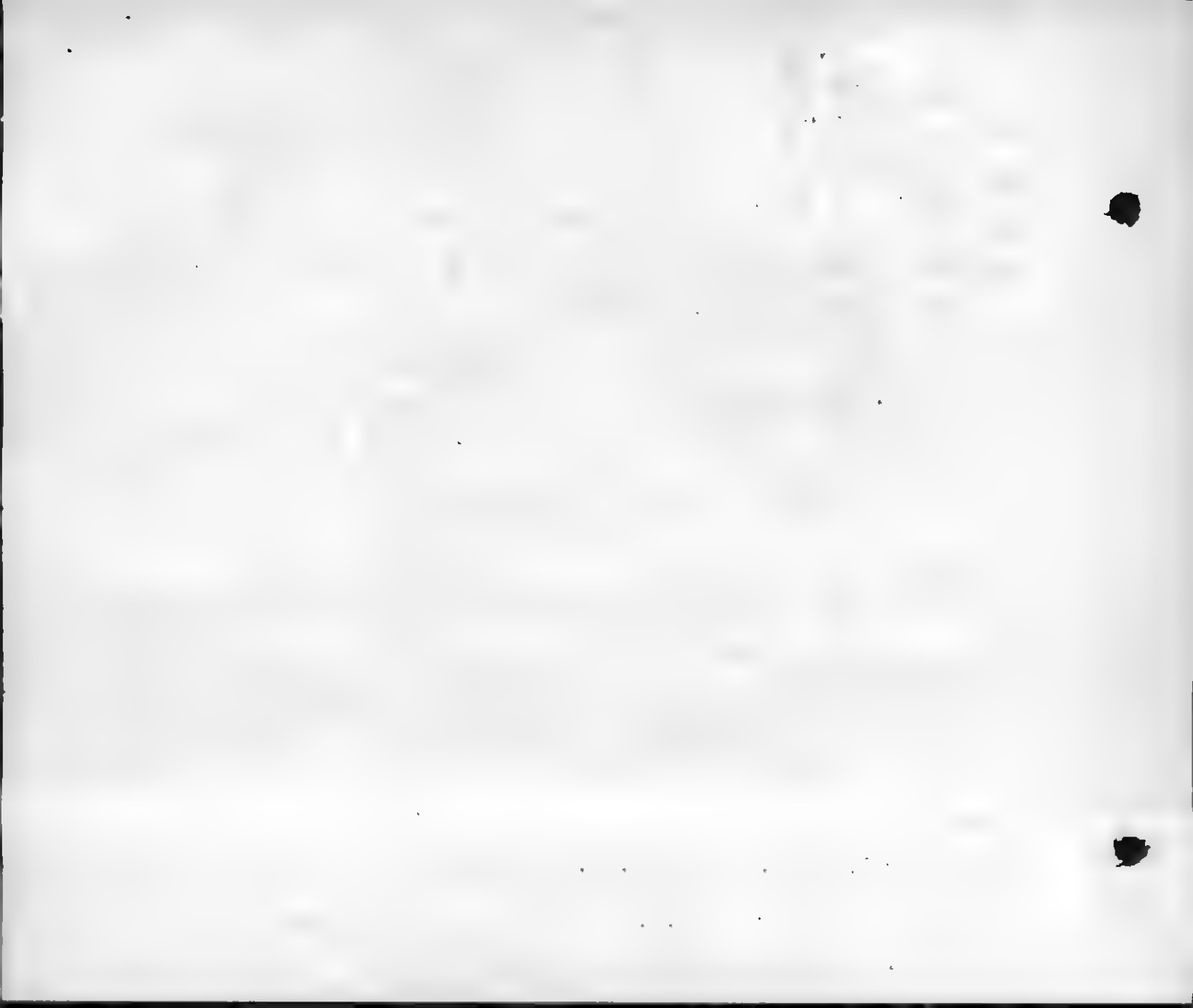
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1035 Maiden Choice Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Craig		4. DATE OF DEATH Month Day Year March 28, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1891
9. AGE (in years last birthday) 67 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME George J. XXXXXXXXXX Goeller		14. MOTHER'S MAIDEN NAME Eva Schrauder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 212 32 6999	
17. INFORMANT Eva G. Goeller		Address 1035 Maiden Choice Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from Jan 1945 , to March 28, 1959 , that I last saw the deceased alive on March 28, 1959 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Darby, M. D.		ADDRESS (Street, city or town, state) DATE SIGNED 8/12/2000	
PHYSICIAN'S NAME (Type) William A. Darby, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/31/59	22c. NAME OF CEMETERY OR CREMATORY U.S. National	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR DATE APR 1 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hubbard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02735

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Balt</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Towson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monkton Rd</u>				d. STREET ADDRESS <u>431 E. Penna</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Crump</u> Middle Last				4. DATE OF DEATH <u>March</u> Month <u>7</u> Day <u>1959</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-15-03</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 24 yrs. Months Days Hours Min		11 BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Order</u>				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Lucy Crump</u> Address <u>471 E. Penna Towson</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. C'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. C'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3/9/59</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr</u> ADDRESS <u>Baltimore</u>				24a. REC'D BY REGISTRAR <u>10'59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, mailing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2764

CERTIFICATE OF DEATH

02736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 53 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 4505 Old Annapolis Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GORDON		First Middle Last L DaSHIELDS		4. DATE OF DEATH Month Day Year March 28 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 4, 1923		9. AGE (In years last birthday) 36 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing Co.		11. BIRTHPLACE (State or foreign country) Brooklyn, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William DaShields				14. MOTHER'S MAIDEN NAME Louise Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv. ce) Yes WW II		16. SOCIAL SECURITY NO. 215-18-7589		17. INFORMANT Address Clin. Rec., Vet Adm Hospital, Fort Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE 11X DUE TO GRANULOMA FUNGOIDES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X attended the deceased from February 3, 19 59 , to March 28, 19 59 , at Fort Howard, Md. , and that death occurred at 5:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/30/59							
ACTUAL SIGNATURE John W. Crawford		M.D.					
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH FT HOWARD, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Schwab Funeral Home 2101 Frederick Ave., Balto., Md				24a. REC'D BY REGISTRAR MAR 31 59		24b. REG. STRAP'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

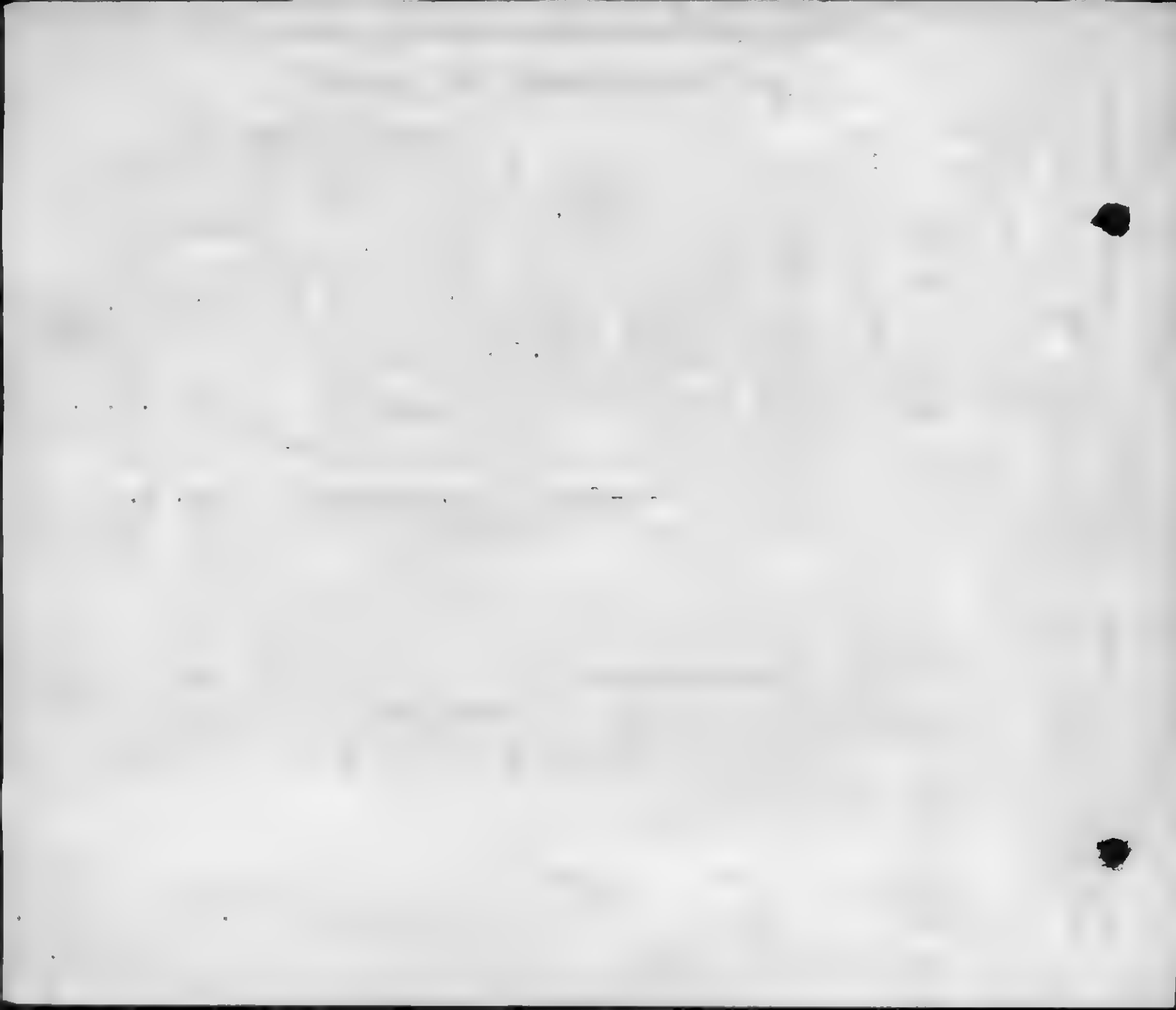
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2765 CERTIFICATE OF DEATH

02507

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oella</u>		LENGTH OF STAY (in this place) <u>30 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oella</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Logtown</u>				STREET ADDRESS (If rural give location) <u>16 Logtown</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Irene Myra Dayhoff</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 16th., 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 14, 1899</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BURLING IN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton & Woolen Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>William Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Engles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-6363</u>		17. INFORMANT & ADDRESS <u>Mr. Edward Dayhoff Oella, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Vascular disease</u>						<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>-</u>							
19a. DATE OF OPERATION <u>19</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-4</u> , 19 <u>55</u> , to <u>3-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-7</u> , 19 <u>59</u> , and that death occurred at <u>9 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>George E. Bugstorf</u>		DATE THEREOF <u>3/19/1959</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rogers Ave. Ellicott City Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>MAR 19 59</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>		ADDRESS <u>Catonsville, Md.</u>	



2715

CERTIFICATE OF DEATH

02738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1212 Leeds Terrace</u>				d. STREET ADDRESS <u>1212 Leeds Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Iola</u> Middle <u>M.</u> Last <u>Delosier</u>				4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/16/1862</u>	
9. AGE (In years last birthday) <u>96</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Delosier</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Mock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr John E. Delosier</u> Address <u>1232 Leeds Terrace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u> </u> <u> </u> 19 <u> </u> p. m. <u> </u> <u> </u> <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>1953</u> to <u>3-18</u> , 1959, that I last saw the deceased alive on <u>3-17</u> , 1959, and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl Pass</u> M.D. <u>400 Wilkens Ave</u>				DATE SIGNED <u>3-19-59</u>			
PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>				<u>400 WILKENS AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Son, Baltimore, Md.</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR DATE <u>MAR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Chas S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2766

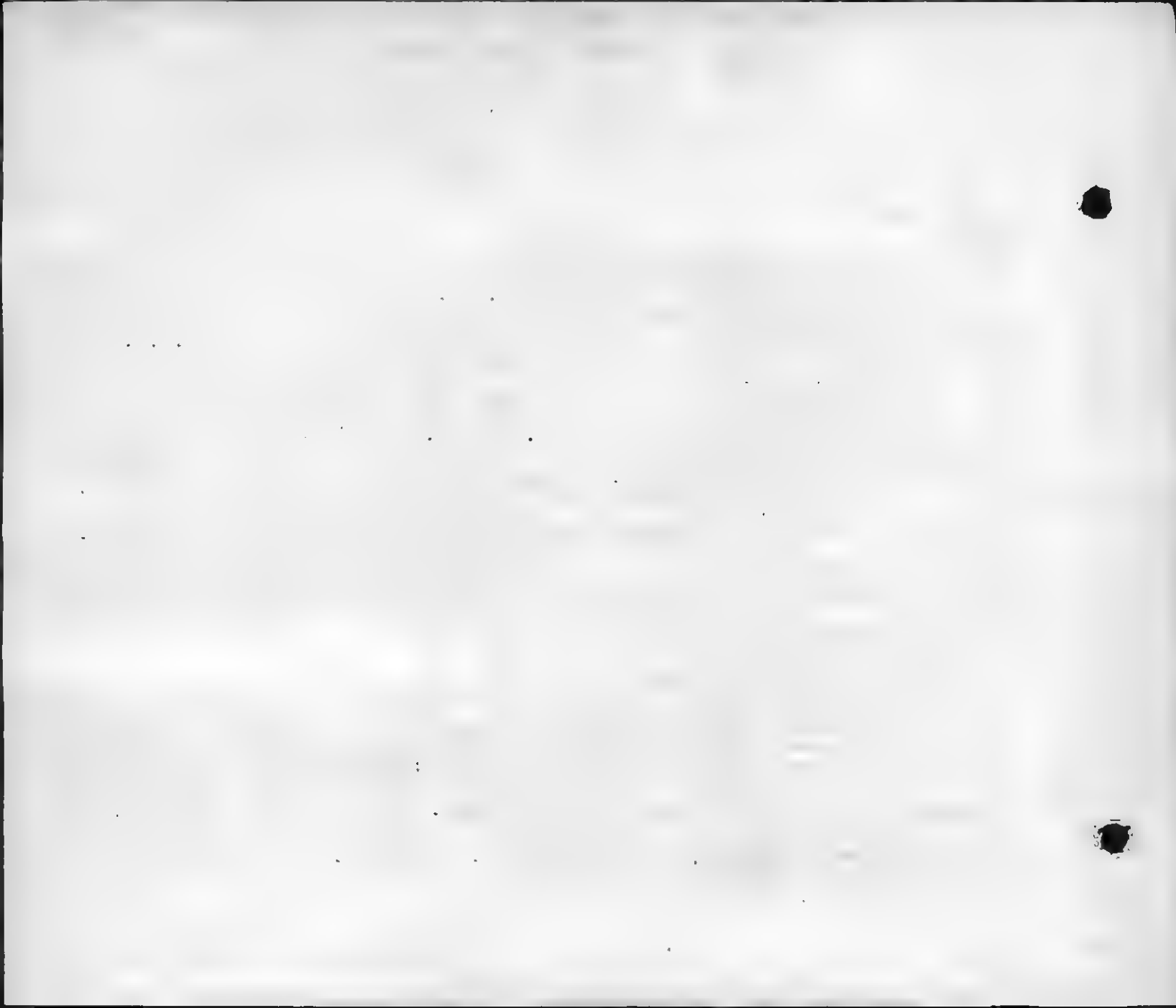
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)				c LENGTH OF STAY IN 1b Essex (21)			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 930 Thompson Blvd				d STREET ADDRESS 930 Thompson Blvd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Dietrich, Last March				4. DATE OF DEATH Month 31 Day 19 Year 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1888	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min 70	IF UNDER 24 HRS Months 70 Days 70 Hours 70 Min 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dietrich				14. MOTHER'S MAIDEN NAME Anna (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs. Daisy M. Dietrich, 930 Thompson Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bronchogenic carcinoma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 13 mo. 15 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from 9/2 , 19 53 , to 3/31 , 19 59 , that I last saw the deceased alive on 3/24 , 19 59 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 S. Taylor Avenue DATE SIGNED 4/3/59							
ACTUAL SIGNATURE Joseph Miceli M.D.				PHYSICIAN'S NAME (Type) Joseph Miceli M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4-4-59		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	
22d. LOCATION (City, town, or county) Baltimore				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 S. Paul Street				ADDRESS 108 S. Taylor Ave. Baltimore 21, Maryland		24a. REC'D BY REGISTRAR DATE Apr 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2767

CERTIFICATE OF DEATH

02740

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
c. LENGTH OF STAY IN 1b 61 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 3229 ST PAUL STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ARTHUR W. DIEZEL		4. DATE OF DEATH March 18 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JULY 25, 1914
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assignment Clerk		10b. KIND OF BUSINESS OR INDUSTRY BOASI	11. BIRTHPLACE (State or foreign country) SHAMOKIN
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME HARRY A DIEZEL		14. MOTHER'S MAIDEN NAME ROSEANNE FISHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW-11		16. SOCIAL SECURITY NO. 178-05-2498	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, ACUTE 430.1 YOUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PYELONEPHRITIS, CHRONIC, BILATERAL (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 18 HRS. 12 YRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SUPPURATIVE CYSTOTOMY - Operation - March 1959		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from January 16 1959 to March 18 1959 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John W. Crawford M.D.			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, FORT HOWARD, MARYLAND 3/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-23-59	22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, 6009 Harford Rd.		24a. REC'D BY REGISTRAR MAR 23 59	24b. REGISTRAR'S SIGNATURE John A. Hanks

WM. COOK-BLIGHT INC 6009 HARFORD RD Baltimore Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2768

CERTIFICATE OF DEATH

Reg. Dist. No.

02741

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 3Yr. 10Mo. 27D	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard & Enoch Pratt Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
II. NAME OF DECEASED (Type or print) First Middle Last Katherine Merron Dishaw		4. DATE OF DEATH Month Day Year March 26 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1881
9. AGE (In years last birthday) yrs 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY United States		13. FATHER'S NAME Hugh Merron	
14. MOTHER'S MAIDEN NAME Mary LaChapelle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 7 years 5 yr + 11
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Symdrome & Cerebral arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 1955 to March 26, 1959 , that I last saw the deceased alive on March 25, 1959 , and that death occurred at 9:20 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED W.W. Elgin M.D. The Sheppard and Enoch Pratt Hospital 3/28/59			
ACTUAL SIGNATURE W.W. Elgin		PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3-27-59	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Massena, New York	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Caroline L. Hume			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02742

2769

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3yr6mth26dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
e. STREET ADDRESS 2211 Taylor Avenue							
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth W. Dobe				4. DATE OF DEATH Month Day Year MARCH 27 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 15, 1875	
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Heinz				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterioscl. Cardiovascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 26, 1959 to March 27, 1959 , that I last saw the deceased alive on 3/27/59 , 1959, and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED 3/27/59							
PHYSICIAN'S NAME (Type) STELLA WACHSLER				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-30-59		Baltimore Cemetery		East North Avenue Balto	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth Inc - 1735 Hanford St				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 31 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

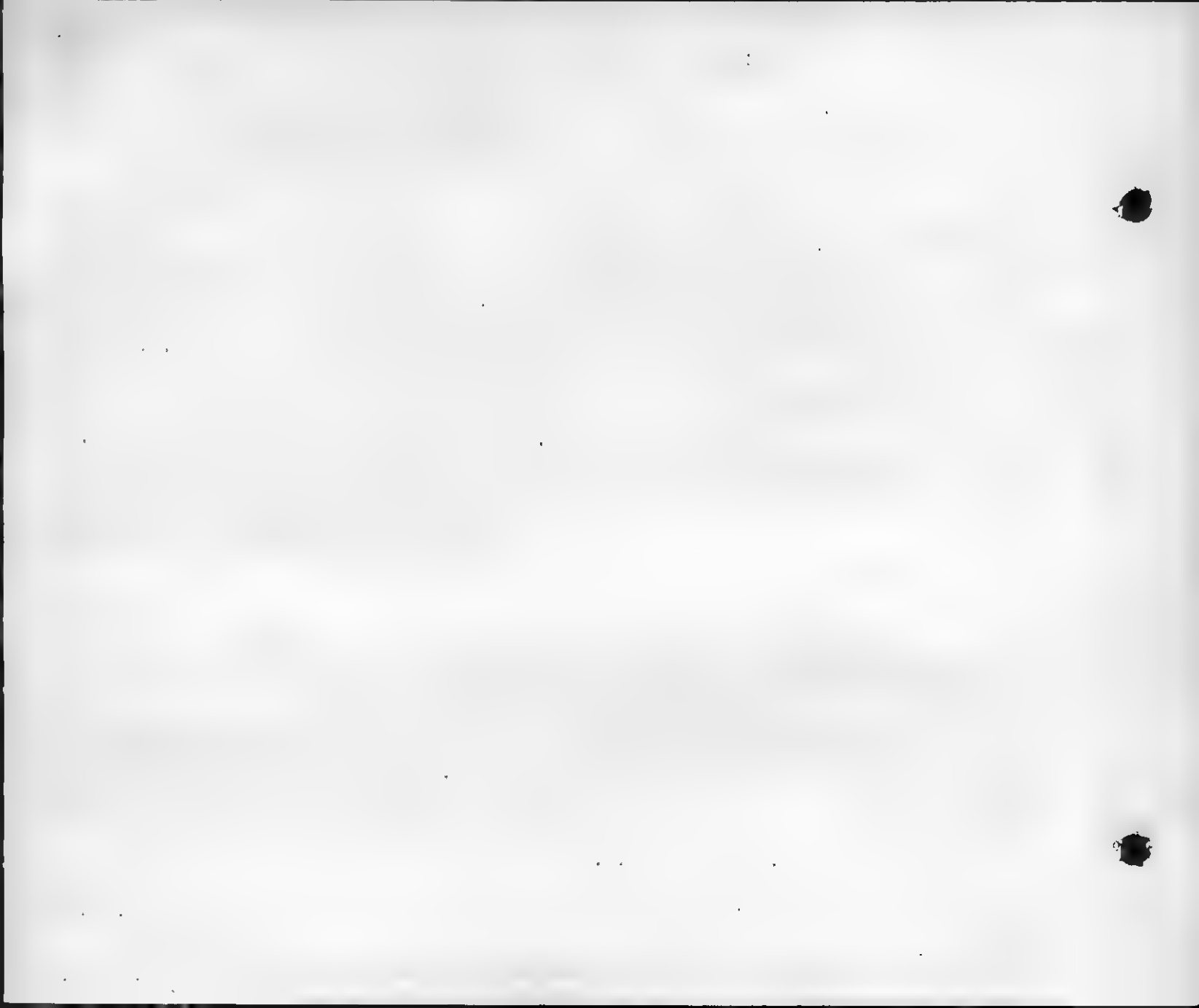
02743

2770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Joanela Driscoll		4. DATE OF DEATH Month Day Year March 25 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) Roxbury, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Denis Driscoll		14. MOTHER'S MAIDEN NAME Catherine Donohue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sr. M. Peter Fourier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Hypertensive Cardio- Renal - Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1955 to March 1959 , that I last saw the deceased alive on March 24 1959 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Road Towson, Md. 3/25/59	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-26-59	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		24a. REC'D BY REGISTRAR MAR 26 '59	
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02744

2771

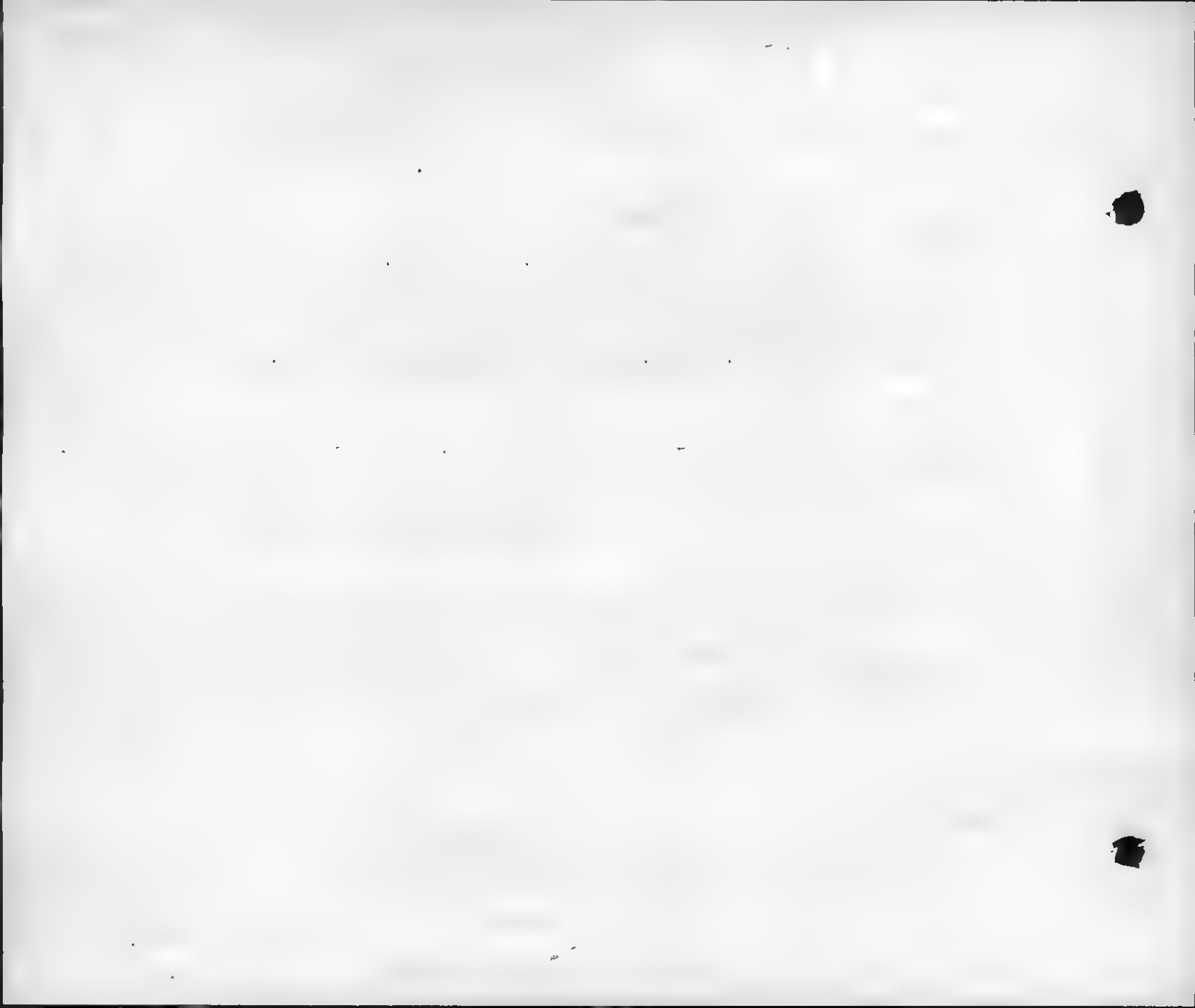
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508 Windsor Mill Road		d. STREET ADDRESS 5508 Windsor Mill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) JOHN BROOKE DUVALL, Sr.		4. DATE OF DEATH Month March Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 3, 1879
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Vice Pres. Balto. Transit		10b. KIND OF BUSINESS OR INDUSTRY St. Margaretss Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Duvall		14. MOTHER'S MAIDEN NAME Mary Stallings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. 213-05-9670	
17 INFORMANT Matilda E. Duvall - 5508 Windsor Mill Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (Recurrent) DUE TO Arterio-Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs. (c) 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 22 , 19 42 , to March - 4 , 19 59 , that I last saw the deceased alive on March 3rd , 19 59 , and that death occurred at 4:57 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty St. - Balto. - Md.	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE SIGNED 3-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/1959	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Hghts. Ave.	
24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Armacost	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2772 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02745

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1yr 27dys		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland d. STREET ADDRESS 315 Milton Avenue	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		4. DATE OF DEATH Month March Day 19 Year 19 59	
5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 29, 1884 9. AGE (in years last birthday) 74 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown 16. SOCIAL SECURITY NO 213-10-90604		14. MOTHER'S MAIDEN NAME Unknown 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Acute Cordear failure DUE TO (b) Hypertension Cordear Caravala DUE TO (c) dissection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) On 2-22-59 A5:15a.m. pt. slipped on wet floor, falling on left side and sustaining an intertrochanteric fracture of the left femur. 20c. TIME OF INJURY Month 2 Day 22 Year 1959 Hour 5:15 a.m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital 20f. (City or town) Catonsville 2, Maryland (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>George M. Kieffer</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) George M. Kieffer, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 19, 1959			
22a. BURIAL, CREMATION REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



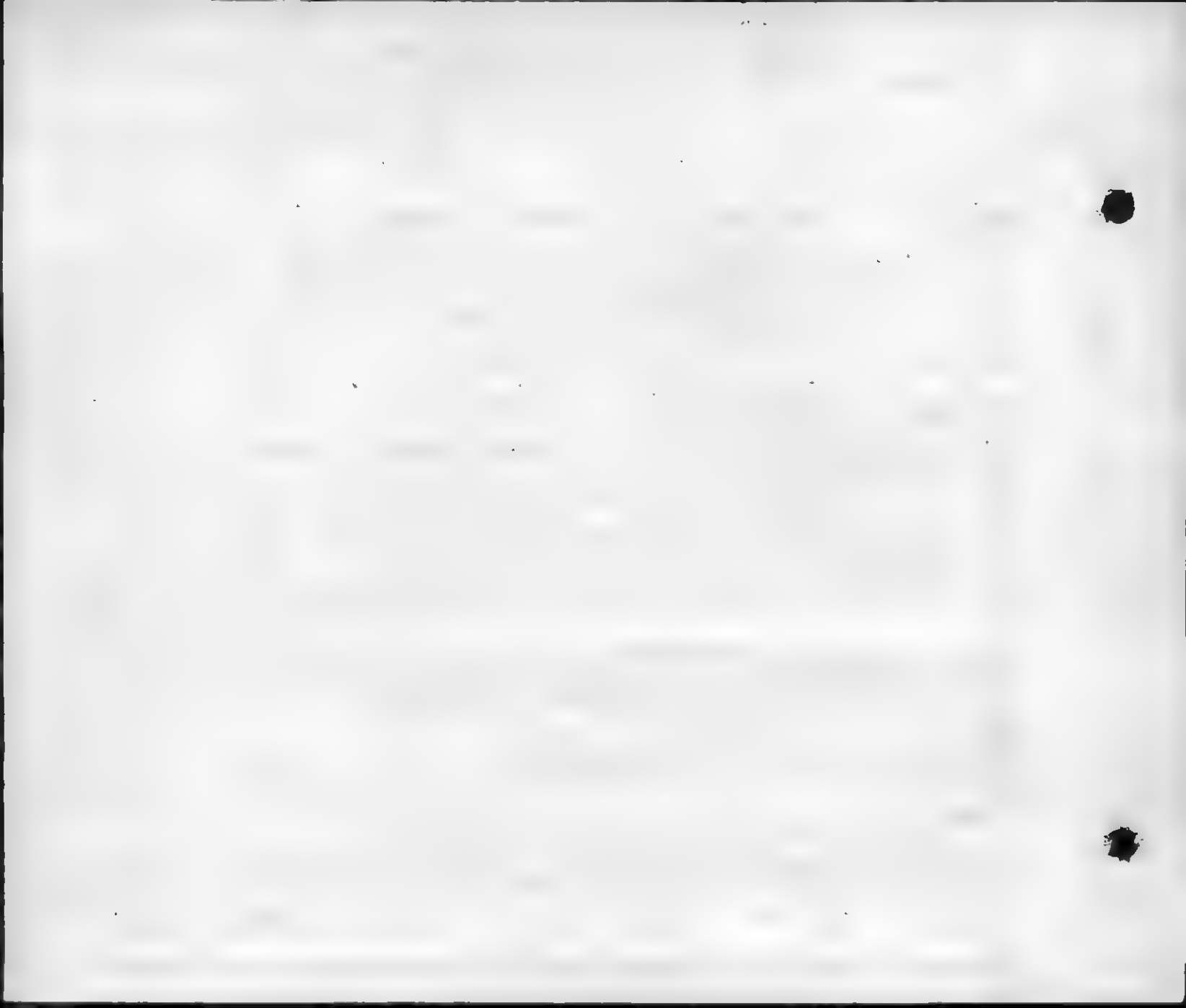
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
 Items 2, 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100
 2773
 CERTIFICATE OF DEATH

02746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reeb Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO	
c. LENGTH OF STAY IN 1b 1 YR		d. STREET ADDRESS Honeewood Hpts.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4501 ESSEX Rd - 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AGNES MOORE EGGERTON		4. DATE OF DEATH MAR 2 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 17, 1881
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR: Months 2 Days 3 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPARISON		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALFRED BYRD MOORE		14. MOTHER'S MAIDEN NAME JOSEPHINE BONAPARTE CONWAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-26-9802	
17. INFORMANT C. E. ODEHEIMER		Address 619 Suddbrook Rd. Pikesville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4:30.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20, 1958 , to Feb Mar 2, 1959 , that I last saw the deceased alive on Mar 2, 1959 , and that death occurred at 4:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Waverly S. Green, Jr. M.D. Pikesville 8, Md		DATE SIGNED Mar 2, 1959	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-4-59	22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT	22d. LOCATION (City, town, or county) (State) BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS Co. 4905 YORK RD		24a. REC'D BY REGISTRAR DATE MAR 3 1959	
24b. REGISTRAR'S SIGNATURE John S. Hume			



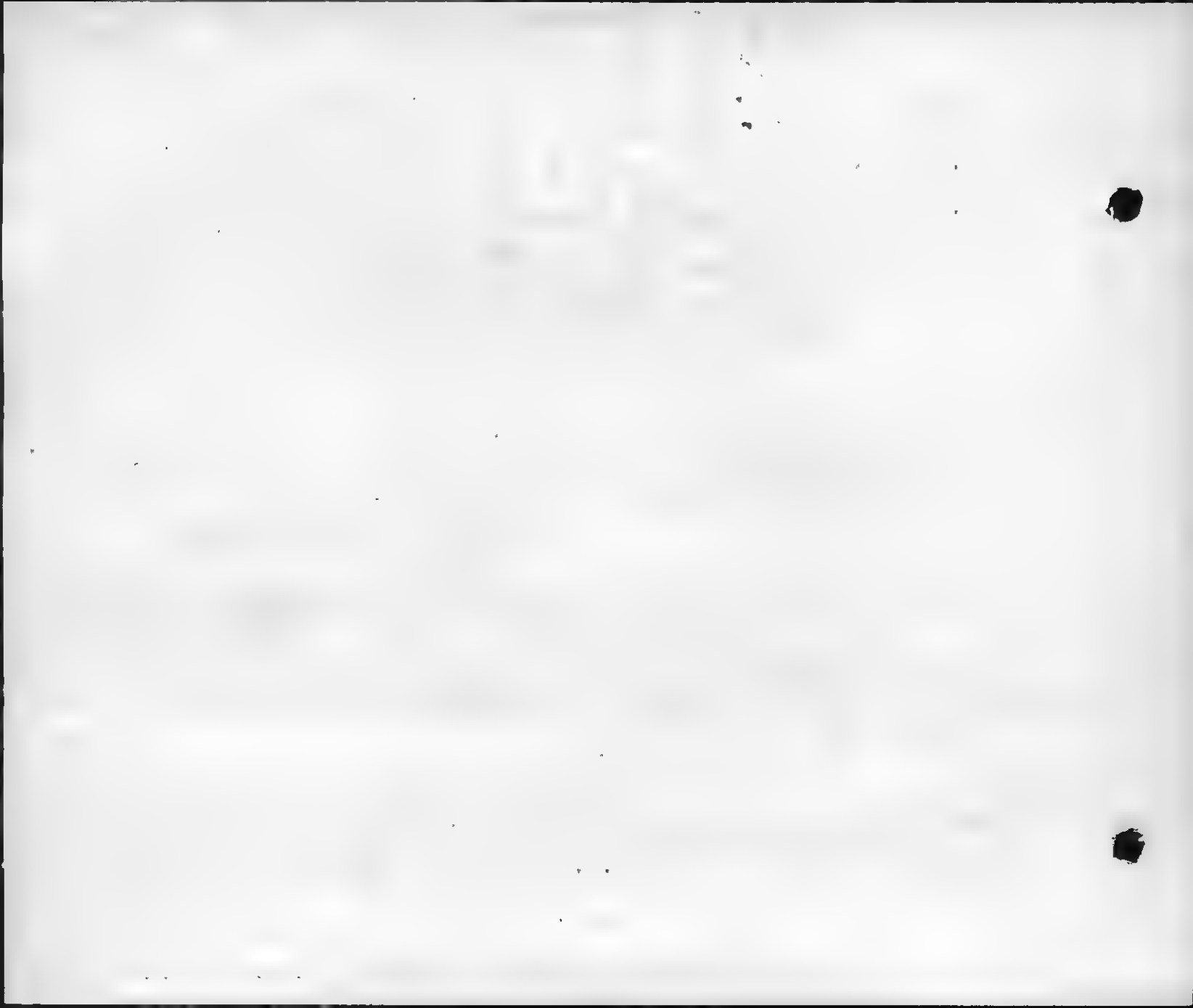
2774

CERTIFICATE OF DEATH

Reg. Dist. No.

02747

1. PLACE OF DEATH COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD Middle DRAKE Last EISENHOWER		4. DATE OF DEATH MARCH 5 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 6, 1898
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCOMOTIVE FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME DANIEL EISENHOWER		14. MOTHER'S MAIDEN NAME JENNIE DRAKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 215-18-7764	
17. INFORMANT Hospital Records, Mt. Wilson State Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/20 , 19 59 , to 3/5 , 19 59 , that I last saw the deceased alive on 3/5 , 19 59 , and that death occurred at 1:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.		DATE SIGNED	
NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL CREMATION, REMOVAL (Specify) 39-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Wm. McManamy, Jr.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell, Baltimore, Md.		24a. REC'D BY REGISTRAR DATE MAR 13 1959	
24b. REGISTRAR'S SIGNATURE Wm. S. Kiser			



2716

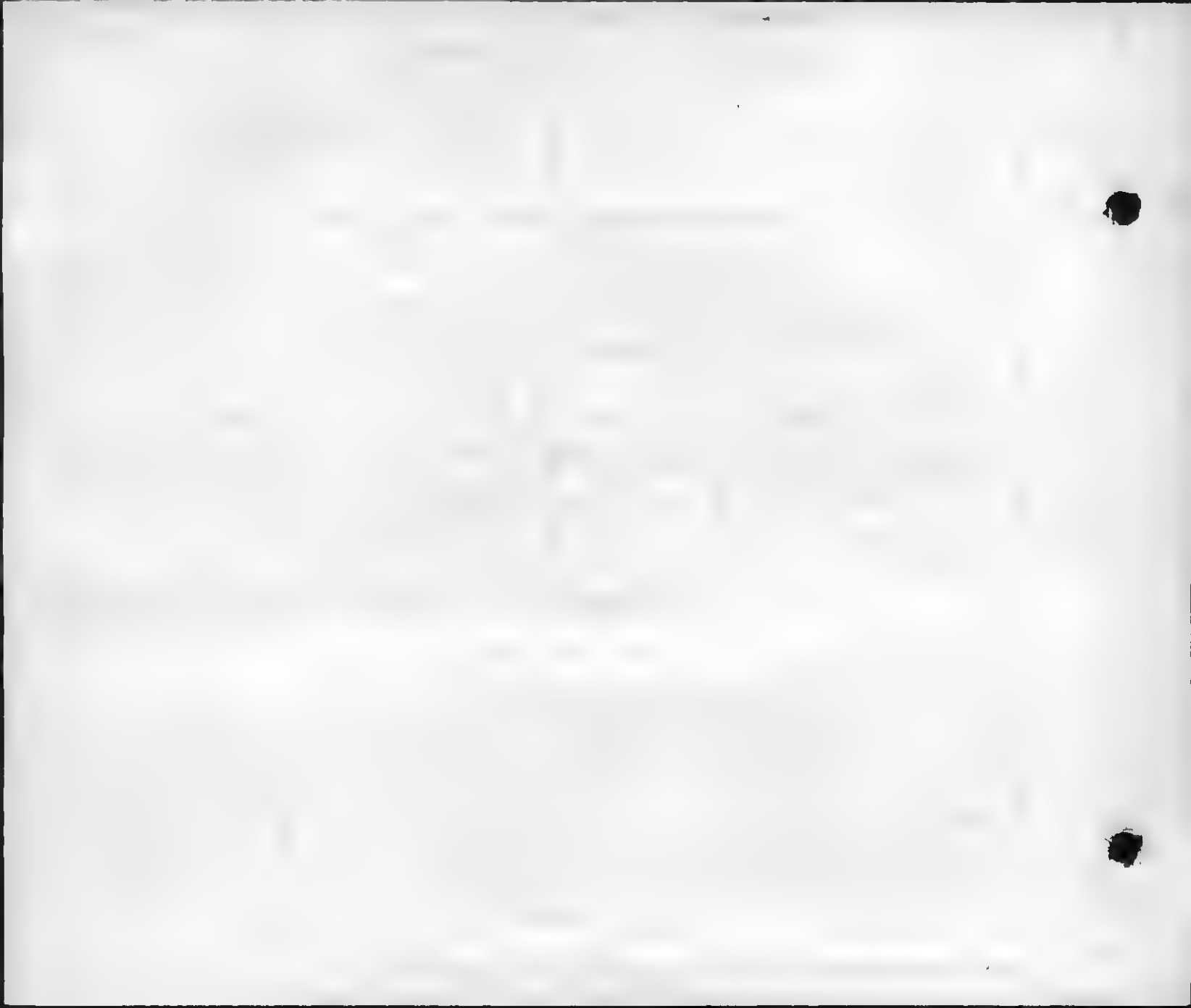
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus c. LENGTH OF STAY IN 1b 4 mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4202 Leeds Avenue				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 4202 Leeds Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Oatha Middle Thomas Last Ellis		4. DATE OF DEATH Month March Day 29 Year 1959		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1885		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance man - retired				10b. KIND OF BUSINESS OR INDUSTRY real estate				11. BIRTHPLACE (State or foreign country) Warrenton, Va.				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Lewis Ellis				14. MOTHER'S MAIDEN NAME unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-07-6584				17. INFORMANT Alma C. Ellis, wife Address 4202 Leeds Avenue 29							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour 9.15 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/3 , 19 59 , to 3/29 , 19 59 , that I last saw the deceased alive on 3/27 , 19 59 , and that death occurred at 2 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1227 Wash. Blvd. DATE SIGNED 3/31/59																							
ACTUAL SIGNATURE John P. Urlock, Jr. M.D.				PHYSICIAN'S NAME (Type) John P. Urlock, Jr.				1227 Washington Blvd.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 1, 1959				22c. NAME OF CEMETERY OR CREMATORY Western Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore Md.											
23. FUNERAL DIRECTOR'S SIGNATURE G. Russell Thomas				ADDRESS 4204 Leeds Avenue				24a. REC'D BY REGISTRAR 29 DATE APR 2 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas											

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

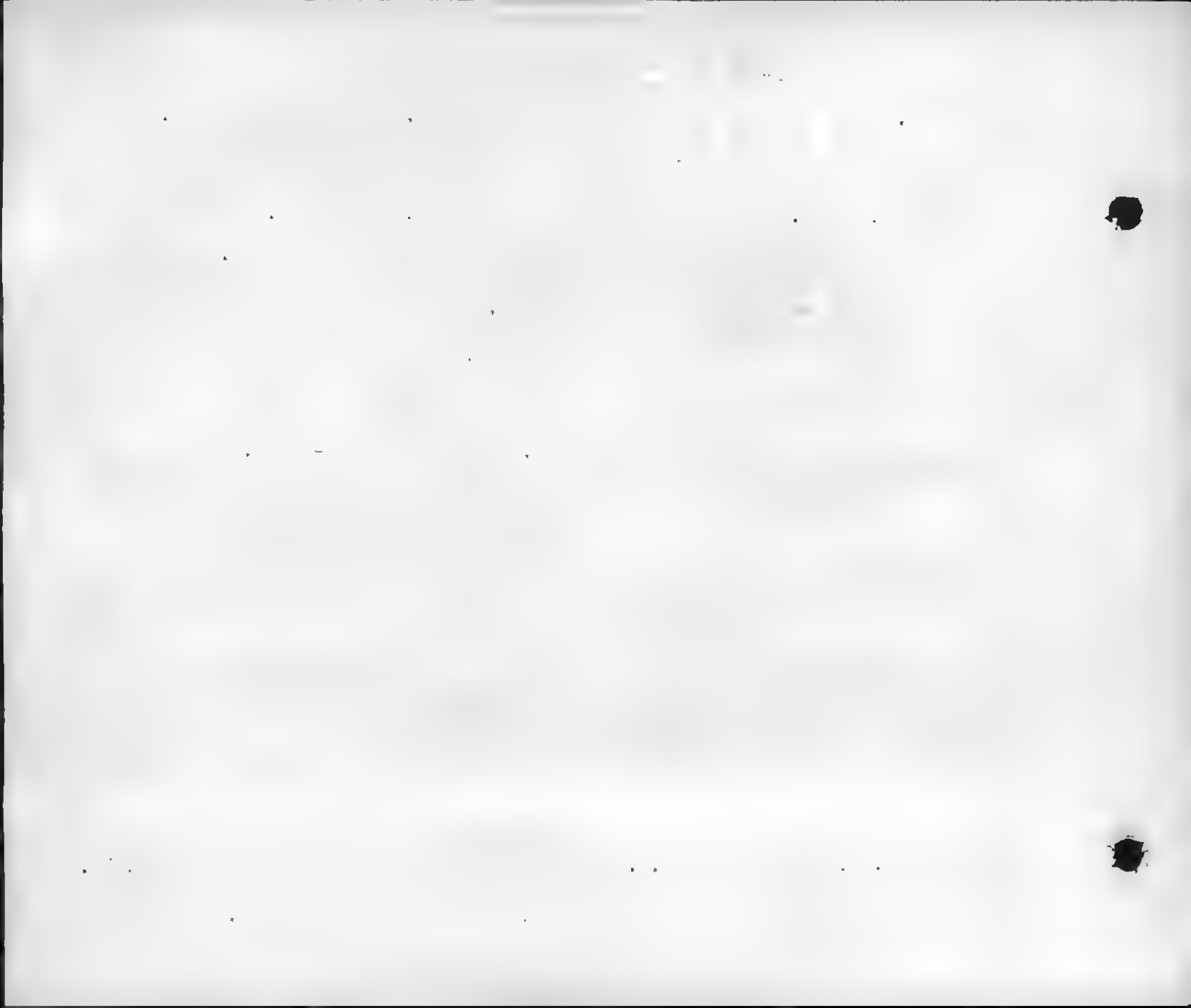
2775

CERTIFICATE OF DEATH

02749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklintown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklintown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5907 Cecil Ave.				f. STREET ADDRESS 5907 Cecil Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SALLIE Middle MAY Last ELSEROAD				4. DATE OF DEATH Month Mar. Day 15, Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 8, 1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Md.							
13. FATHER'S NAME Nathan Porter				14. MOTHER'S MAIDEN NAME ? Cavey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Herbert Reynolds-222 E. Medwick Garth #28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, left breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June , 19 57 , to March 15 , 19 59 , that I last saw the deceased alive on March 15 , 19 59 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D. C. MacLaughlin				M.D. 4508 Edmondson Village DATE SIGNED 3/17/59			
PHYSICIAN'S NAME (Type) D. C. MacLaughlin, M.D.				ADDRESS (Street, city or town, state) 4508 Edmondson Village Balto 22, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Hoodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons - Baltor. Md.				24a. REC'D BY REGISTRAR DATE MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Frank	



2776

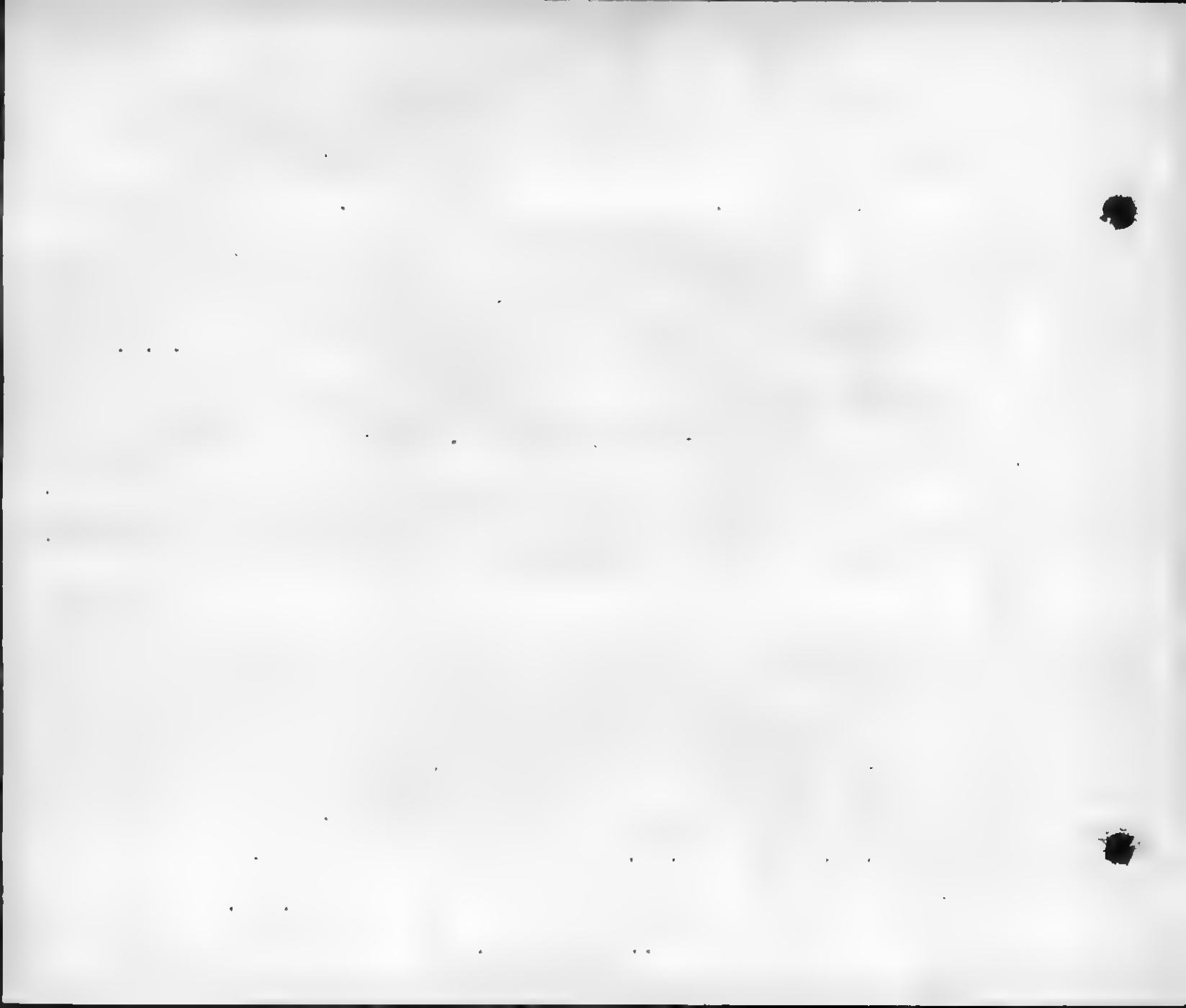
CERTIFICATE OF DEATH

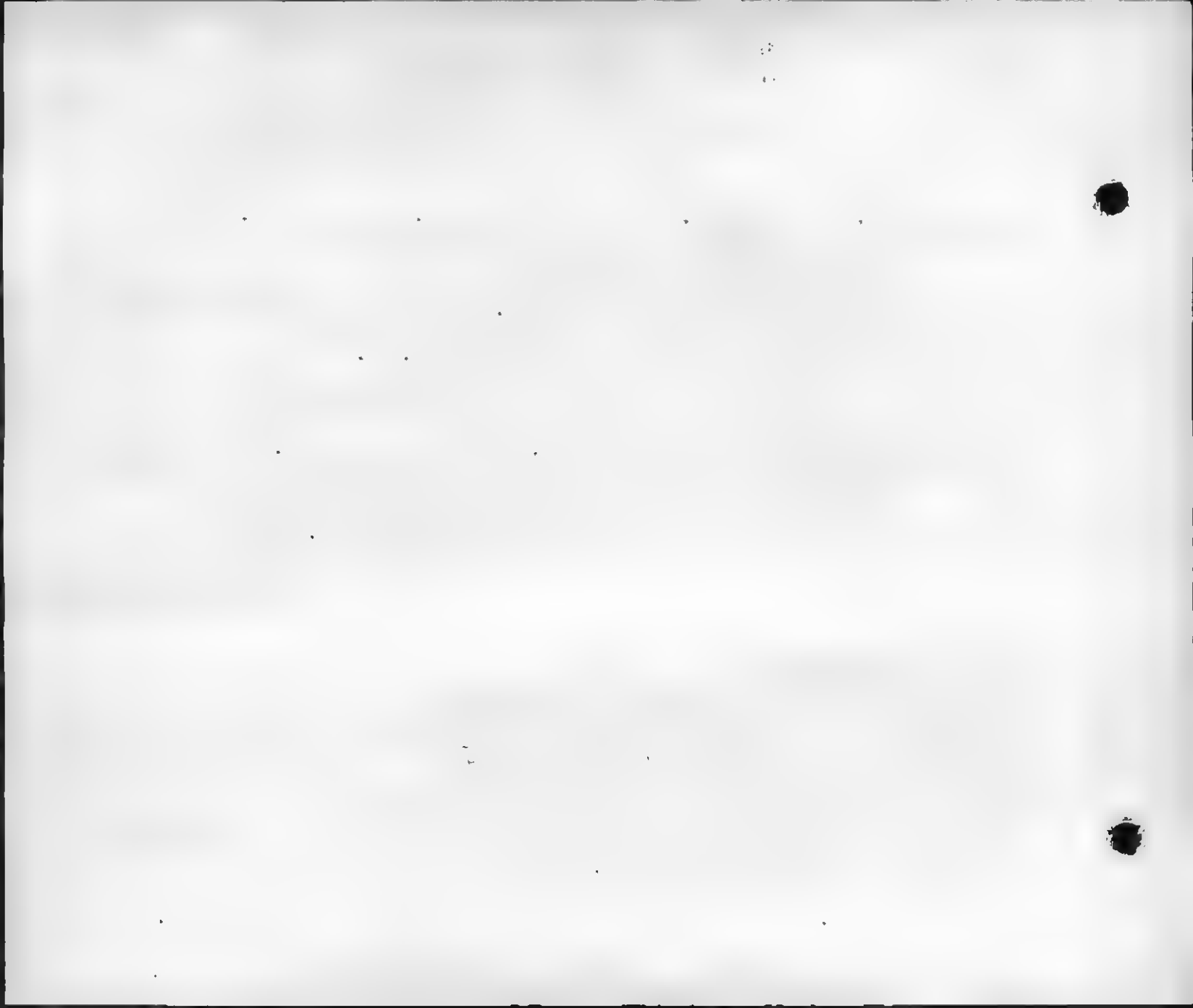
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tanyard Rd.		e. STREET ADDRESS Tanyard Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Lester Chilcoat Ensor		4. DATE OF DEATH Month Day Year 3-12-59 19	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1894
9. AGE (In years last birthday) 64 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner operator	11. BIRTHPLACE (State or foreign country) Maryland
10b. KIND OF BUSINESS OR INDUSTRY farm		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mitchell Ensor		14. MOTHER'S MAIDEN NAME Ozella Chilcoat	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-34-5995	
17. INFORMANT Jodie B. Ensor		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Diabetes DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 9 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) none
21. I certify that I attended the deceased from 6-30-58 , 19___, to 3-12-59 , 19___, that I last saw the deceased alive on 12-24-58 , 19___, and that death occurred at 9:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 3-12-59			
ACTUAL SIGNATURE D. D. Cables		M.D. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Cables, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-16-59	22c. NAME OF CEMETERY OR CREMATORY Black Rock	22d. LOCATION (City, town, or county) (State) Butler, Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		24a. REC'D BY REGISTRAR DATE MAR 18 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02752

2778

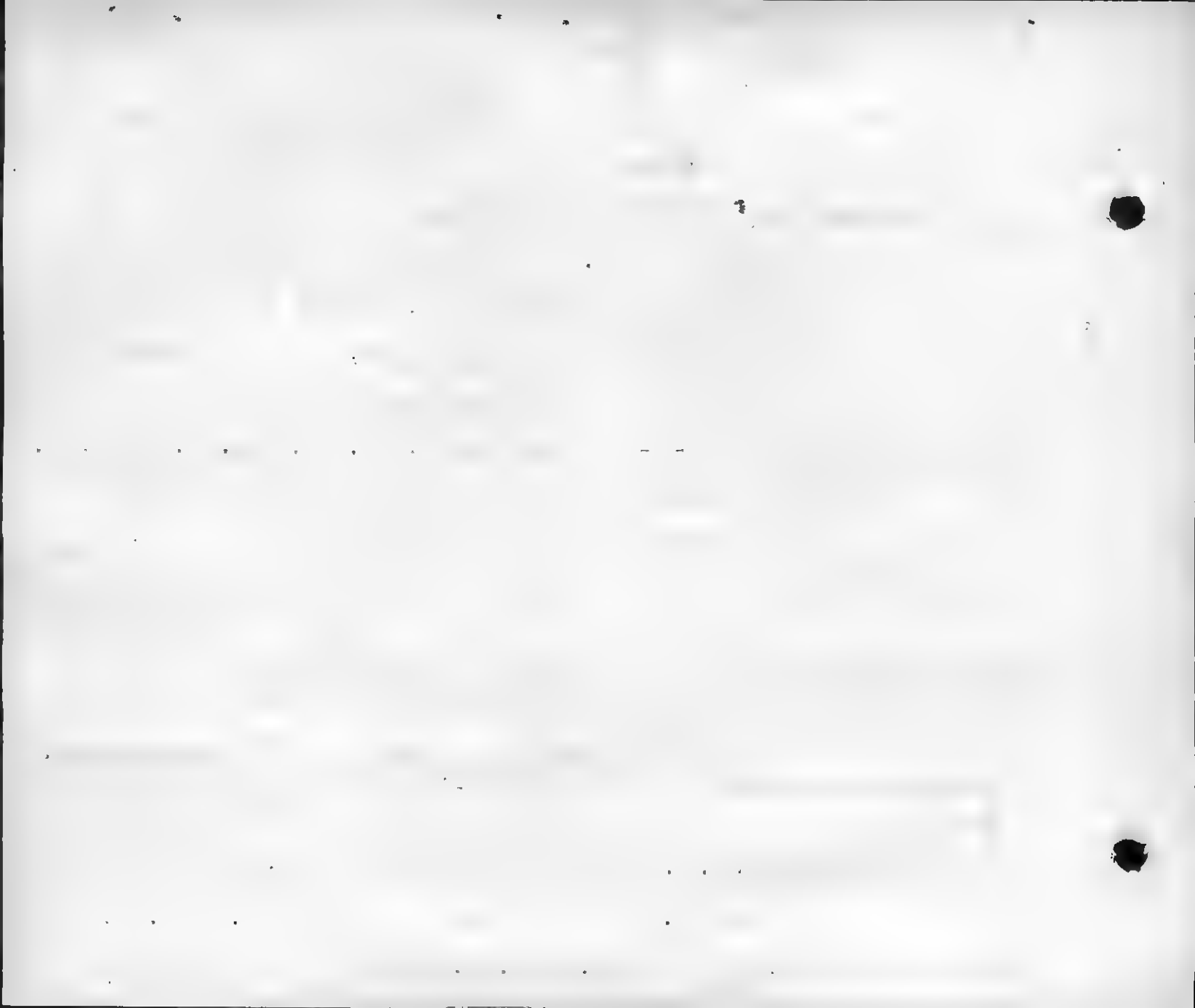
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton			
c. LENGTH OF STAY IN 1b 459 Days				d. STREET ADDRESS Box 44			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle B. Last FITCH				4. DATE OF DEATH Month March Day 14 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1916	
9. AGE (In years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		11. BIRTHPLACE (State or foreign country) Stemmers Run,		12. CITIZEN OF WHAT COUNTRY? Maryland	
10b. KIND OF BUSINESS OR INDUSTRY Garage				13. FATHER'S NAME Thomas Fitch			
14. MOTHER'S MAIDEN NAME Emma McLane				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II			
16. SOCIAL SECURITY NO 217-05-7512				17. INFORMANT Clin Records, Vet. Adm. Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONVULSIVE DISORDER 13.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) ASTROCYTOMA DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH UNKNOWN						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from December 10, 1957 , to March 14, 1959 , and that death occurred at 3:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Armen Bogosian</i> M.D.				PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-18-1959		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	
22d. LOCATION (City, town, or county) (State) Balto. Md.				24a. REC'D BY REGISTRAR MAR 17 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
23. FUNERAL DIRECTOR'S SIGNATURE LA SAHN FUNERAL HOME, 7401 Belair Rd., Balto. Md.							

MEDICAL CERTIFICATION

1. HOSPITAL ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 4 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2779

CERTIFICATE OF DEATH

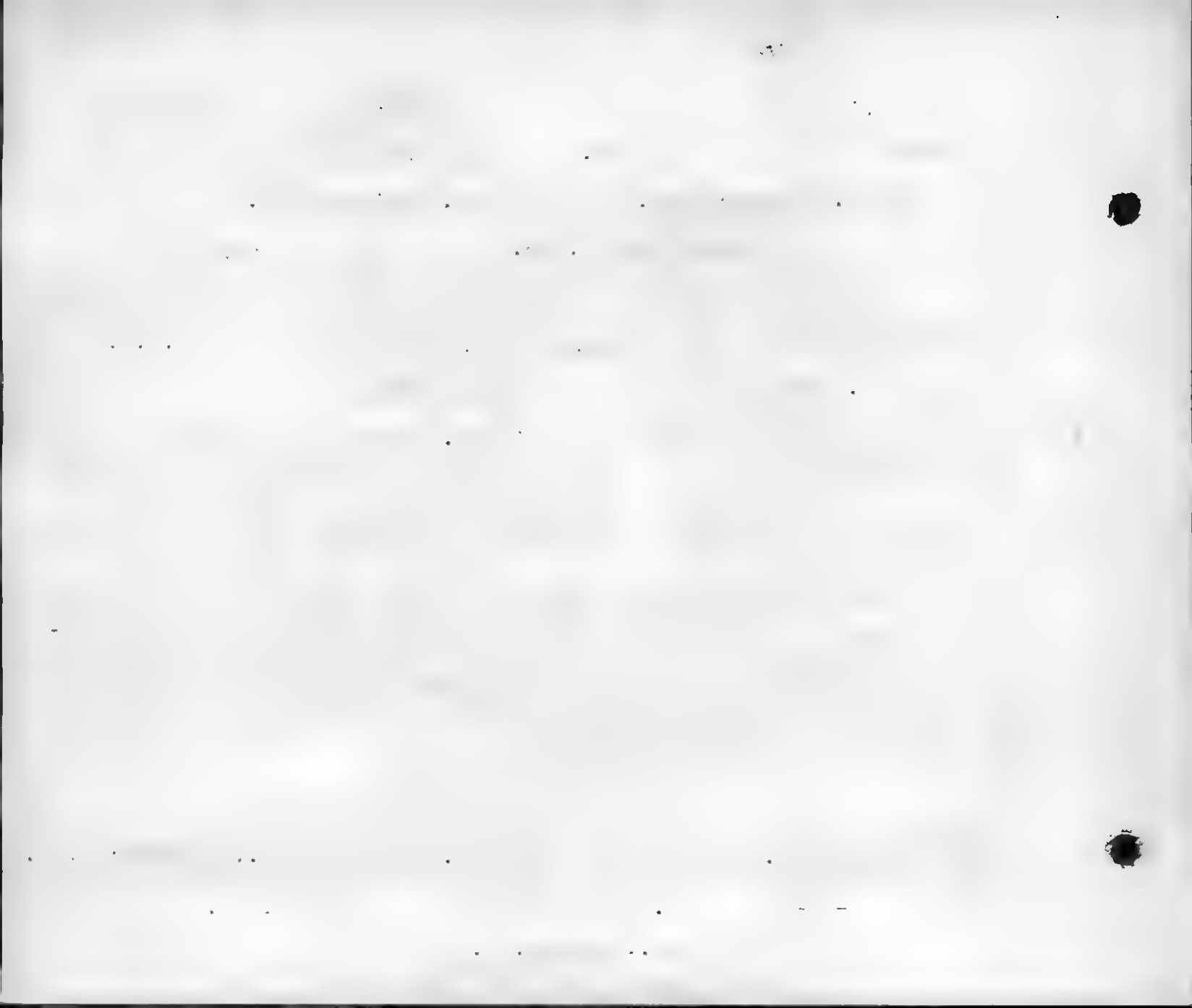
02753

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if first last on residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 W. Seminary Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John Pinkney Frantz, Sr.		4. DATE OF DEATH 3-25-59	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-5-1869
9 AGE (In years last birthday) 89		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance sales		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11 BIRTHPLACE (State or foreign country) Wyoming		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Frantz		14. MOTHER'S MAIDEN NAME Louisa Sewall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 216-32-7887	
17. INFORMANT Louise S. Frantz		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 4:00.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, General. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-29 , 19 52 , to 3-25 , 19 59 , that I last saw the deceased alive on 3-25 , 19 59 , and that death occurred at 10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bennett A. Stoen		DATE SIGNED 3/26/59	
PHYSICIAN'S NAME (Type) Bennett A. Stoen		ADDRESS (Street, city or town, State) 19 W. Seminary Ave., Lutherville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-27-59	22c. NAME OF CEMETERY OR CREMATORY St. James Episcopal	22d. LOCATION (City, town or county) (State) Monkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		ADDRESS 622 York Rd., Towson 4, Md.	
24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaul	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be taken with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2780

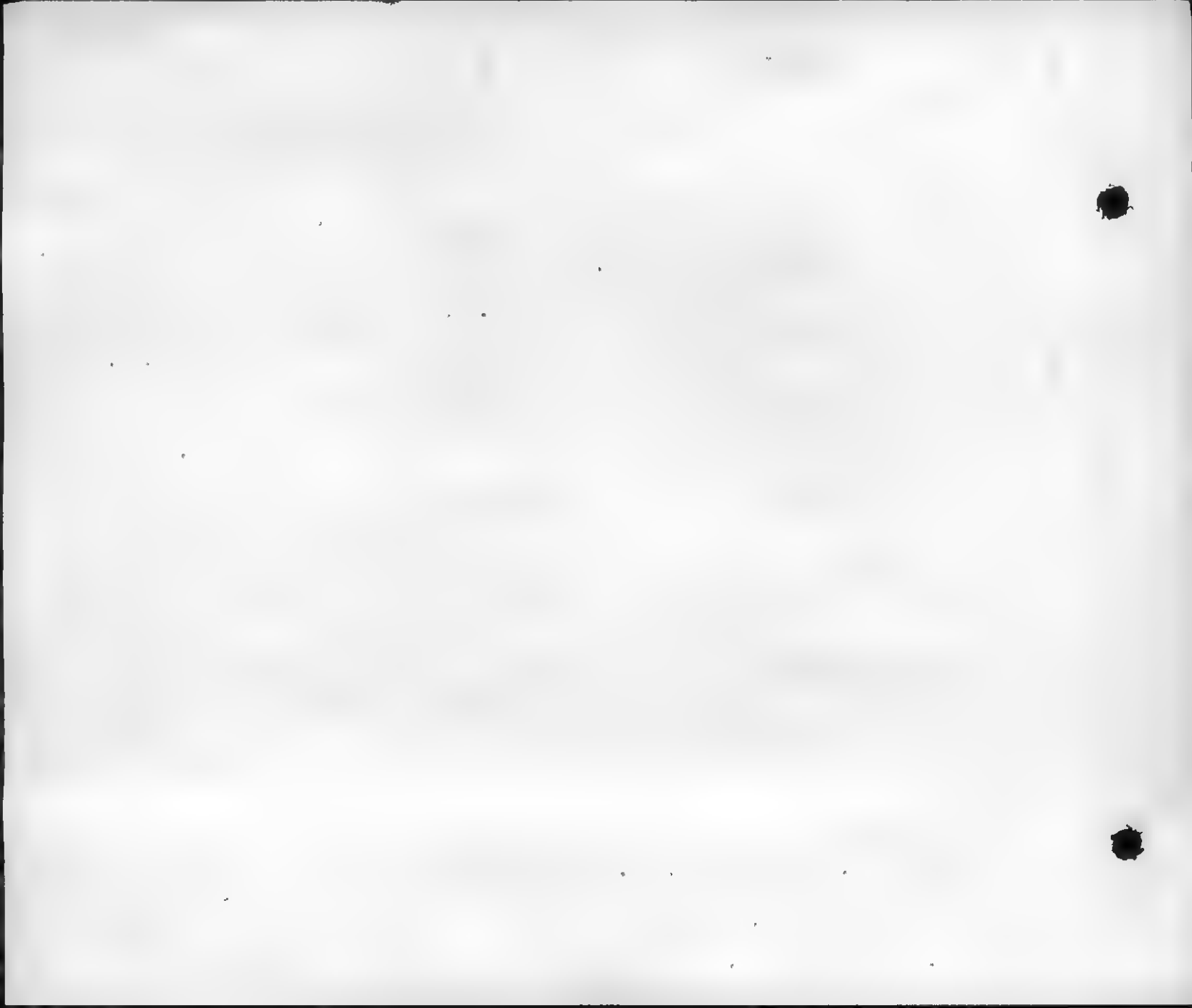
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE Md. c. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 yrs 1 mo 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. STREET ADDRESS 23 Melrose Ave.	
3. NAME OF DECEASED (Type or print) First Lillie Middle G. Last Frazier		4. DATE OF DEATH Month March Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1870
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Missionary Work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S.	
13. FATHER'S NAME Peter T. Pilchard		14. MOTHER'S MAIDEN NAME Dollie Riffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT George Pilchard 2505 Whitney Ave.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 hr. Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1 , 19 57 , to 3/26 , 19 59 , that I last saw the deceased alive on 3/23 , 19 59 , and that death occurred at 6:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson Ave DATE SIGNED 3/27/59			
ACTUAL SIGNATURE Cliff Ratliff M.D.		PHYSICIAN'S NAME (Type) Dr. Cliff Ratliff, Jr. 4605 Edmondson Ave.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 30, 1959	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE MAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur J. H...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2781

CERTIFICATE OF DEATH

02755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Not stated</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RED Daughter's home</u>		d. STREET ADDRESS <u>108 Smithwood</u>	
3. NAME OF DECEASED (Type or print) <u>MAUDES FREELAND</u> First Middle Last		4. DATE OF DEATH <u>3/23/59</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/81</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Edmund Stables</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Cuddihy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Stables Freeland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>Chronic Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/16</u> , 19 <u>58</u> , to <u>March 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>59</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>W H Foard</u> M.D. <u>Manchester, Md</u> DATE SIGNED <u>3/24/59</u> ACTUAL SIGNATURE <u>W H Foard M.D.</u> <u>Manchester, Md</u> PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u> <u>Manchester, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ferris</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mar Nabt + Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon page 3 and should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shown, be detached for use as the burial-transit permit. Then please give the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2782

CERTIFICATE OF DEATH

02756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of Pines</u>				d. STREET ADDRESS <u>29 Trusting ave</u>			
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First <u>a</u> Middle <u>a</u> Last <u>Garber</u>				4. DATE OF DEATH <u>3</u> Month <u>22</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/17/1866</u>	
9. AGE (In years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR: Months <u>9</u> Days <u>15</u> Hours <u>3</u> Min <u>0</u>		IF UNDER 24 HRS: Months <u>0</u> Days <u>15</u> Hours <u>3</u> Min <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic house wife</u>	
11. BIRTH PLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Thomas O. Lindsey</u>				14. MOTHER'S MAIDEN NAME <u>Laura Castrow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-00-100000</u>			
17. INFORMANT <u>Mrs. Clara Tucker</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>331A</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>153</u>							
(c) <u>Diabetes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/6</u> , 19 <u>58</u> to <u>3/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>59</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>3/22/59</u>							
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u> <u>Baltimore, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/24/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Linganore</u>				22d. LOCATION (City, town, or county) (State) <u>Frederick Co Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Hall</u>				24a. REC'D BY REGISTRAR <u>Arthur L. Hines</u>			
ADDRESS <u></u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			
DATE <u>MAR 26 '59</u>							



2783

CERTIFICATE OF DEATH

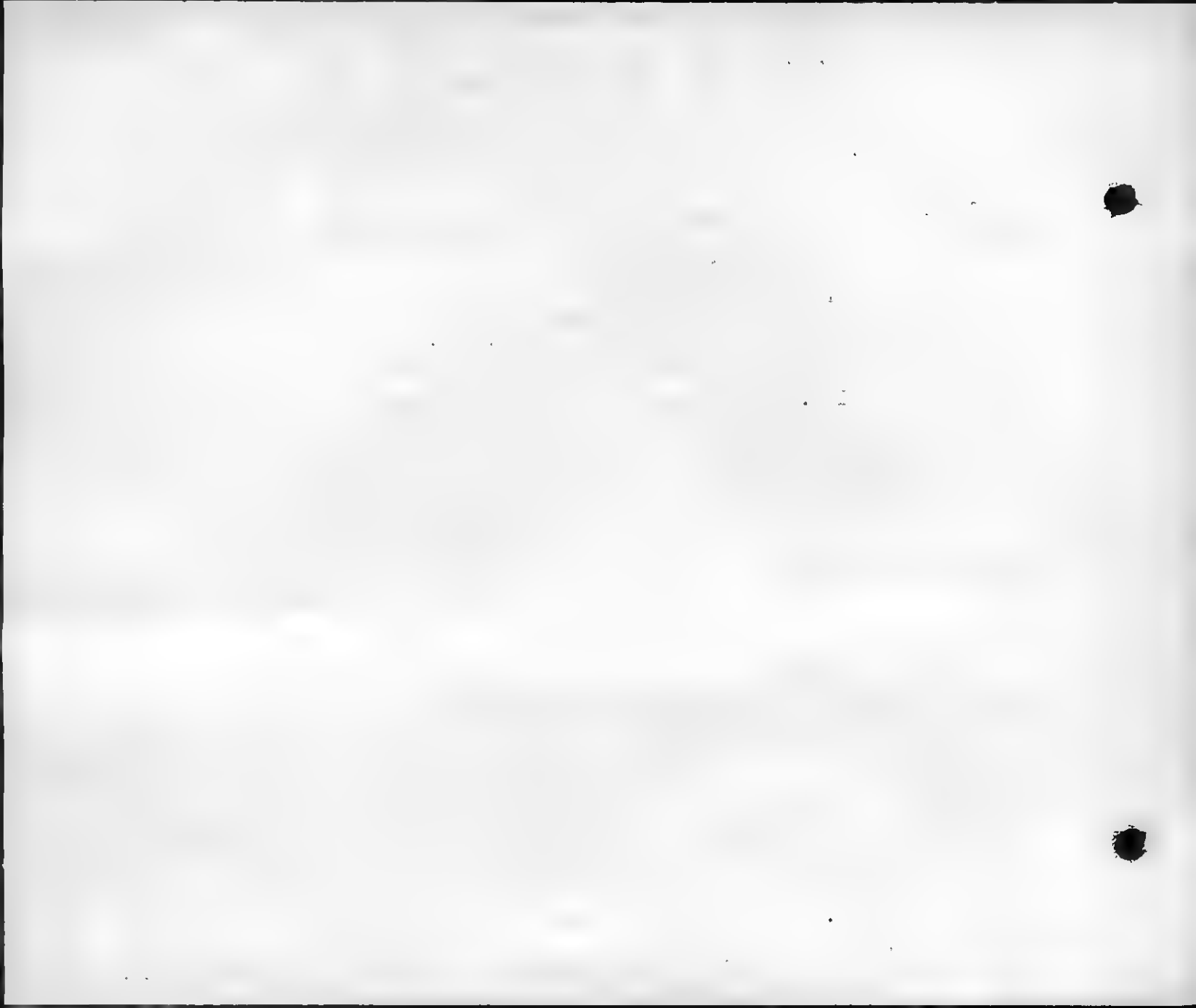
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Belfast Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BETTY Middle D. Last GARRETT		4. DATE OF DEATH Month March Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1883
9. AGE (In years last birthday) 75 yes		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel H. Molesworth	
14. MOTHER'S MAIDEN NAME Memie Daffin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Family records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 hour
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 19, 1959 to March 11, 1959 that I last saw the deceased alive on March 9, 1959 and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL George T. Gilmore M.D.		DATE SIGNED Luther M. B. 3/18/59	
PHYSICIAN'S NAME (Type) GEORGE T. GILMORE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 14, 1959	22c. NAME OF CEMETERY OR CREMATORY Vernon Methodist Cemetery	22d. LOCATION (City, town, or county) (State) White Hall, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE MAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



02758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7912 Ruxway		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Eva Bryan Garrett		4. DATE OF DEATH Month March Day 25 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1879	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Bryan		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-4802		17. INFORMANT Mrs Robert T. Garrett, 5004 La Salle	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SEV YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/11 , 19 58 , to MAR 26 , 19 59 , that I last saw the deceased alive on MAR 23 , 19 59 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 W. PENNA. AV DATE SIGNED 3/26/59		ACTUAL SIGNATURE T. C. Siwinski M.D.			
PHYSICIAN'S NAME (Type) T. C. SIWINSKI		TOWSON 4 MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Hartford Road #14		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within ~~72~~ 2 hours after death.

VS A15 (4)
15M 9/55



2785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 4 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 3013 WESTFIELD AVE			
3. NAME OF DECEASED (Type or print) First GENEVA Middle N. Last GARTSIDE				4. DATE OF DEATH Month MARCH Day 13 Year 1959			
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-1887	9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REG. NURSE		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC HEALTH NURSE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME DR. JOSEPH T. NELSON				14. MOTHER'S MAIDEN NAME MARY IRLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arterio Sclerotic Cardio (c) Vascular disease						INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 11/29, 1954 to 3/12, 1959 , that I last saw the deceased alive on 3/12, 1959 , and that death occurred at 4:47 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Rees		ADDRESS (Street, city or town, state) Cockeysville, Md		DATE SIGNED 3/13/59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-16-59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2786

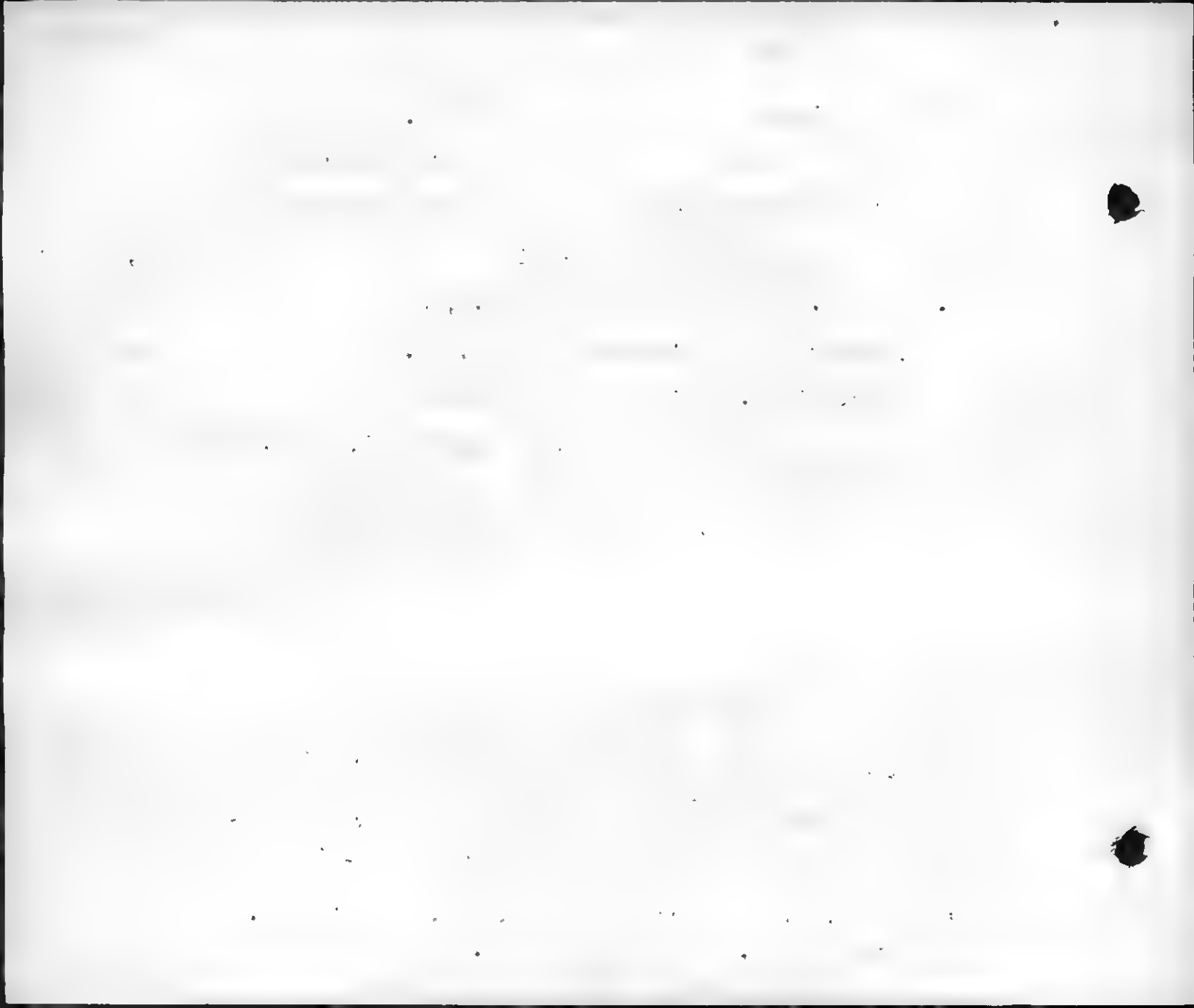
CERTIFICATE OF DEATH

02760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 52 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 908 Bardswell Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Catonsville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 908 Bardswell Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Idora Middle Geppi Last Idora		4. DATE OF DEATH Month March Day 26 Year 19 59	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1911
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR Months 1 Days 26 Hours 15 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Mutzlers	
11. BIRTHPLACE (State or foreign country) Calif.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Antonio D. Geppi		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Miss Anna Geppi, 908 Bardswell Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO With Metastases to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain DUE TO (c) Brain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 59 to March 26 59 that I last saw the deceased alive on March 26 59 , and that death occurred at 8:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3033 W North Ave Balto Md DATE SIGNED Arthur J. Hume			
ACTUAL SIGNATURE Arthur J. Hume		M.D. 3033 W North Ave Balto Md	
PHYSICIAN'S NAME (Type) M Paul Beyerly		Balto Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/30/59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2787

CERTIFICATE OF DEATH

Reg. Dist. No.

02761

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>x Elderwood, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George A. Gill</u> First Middle Last				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-22-76</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>East Electric Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INSPECTOR</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Jacob R. Gill</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Naylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>212-05-3303</u>			
17. INFORMANT <u>wife</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>3-16-59</u> , 19 <u>59</u> , to <u>3-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-16-59</u> , 19 <u>59</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Nachsler</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>STELLA NACHSLER</u>				DATE SIGNED <u>3/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SATER'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Lutherville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Hume</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

02762

2788

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 5 1/2 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) Stella Maris Hospice		e. STREET ADDRESS 1335 Lombard AVE	
3. NAME OF DECEASED (Type or print) First Emil Middle Gissler Last		4. DATE OF DEATH Month March Day 14 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/1871
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Gissler		14. MOTHER'S MAIDEN NAME Mary Wussler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fractured DUE TO (c) Generalized Osteoporosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 1/2 yrs 25 Days 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1953 to March 14 1959 that I last saw the deceased alive on March 13 1959 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7501 3/21 Rd 3/14/59 ACTUAL SIGNATURE Charles F. O'Donnell, M.D. PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Kuch		24a. REC'D BY REGISTRAR DATE MAR 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kirsch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2789

CERTIFICATE OF DEATH

02763

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN b. 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. STREET ADDRESS BOX 359 R.D 8		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSCAR Middle JESSE Last GROFF		4. DATE OF DEATH Month 3 Day 21 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1894	9. AGE (In years last birthday) yrs 64	10. IF UNDER 1 YEAR Months 3 Days 21 Hours 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMBALMER		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		11. BIRTHPLACE (State or foreign country) L.I.S.A	
12. CITIZEN OF WHAT COUNTRY? L.I.S.A		13. FATHER'S NAME AMOS GROFF		14. MOTHER'S MAIDEN NAME EFFIE JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 1st WORLD WAR		16. SOCIAL SECURITY NO. 212-037213		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE 002X DUE TO (b) PULMONARY TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 2-12-58 19____, to 3-21 19____, that I last saw the deceased alive on 3-21- 19____, and that death occurred at 8:07 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland		DATE SIGNED 3-21-59	
PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent					
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 3-24-59		22c. NAME OF CEMETERY OR CREMATORY Balto-National	
22d. LOCATION (City, town, or county) Balto		(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR MAR 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hunt					



2706

CERTIFICATE OF DEATH

02764

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c LENGTH OF STAY IN 1b <u>54 YRS</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7873 ST BRIDGETS LANE</u>		e STREET ADDRESS <u>7873 ST. BRIDGETS LANE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIA LE GRCS</u>		4. DATE OF DEATH Month Day Year <u>MARCH 16 1959</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 30, 1882</u>
9 AGE (In years last birthday) <u>76 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BELGIUM</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>AUGUST LIPPENS</u>		14 MOTHER'S MAIDEN NAME <u>EUGENIE SPITTEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart disease</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yrs</u> <u>15 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1958</u> to <u>3-16-59</u> that I last saw the deceased alive on <u>3-17-59</u> 19 <u>59</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack C Collins</u>		ADDRESS (Street, city or town, state) <u>2 Kensington Baltimore MD</u>	
PHYSICIAN'S NAME (Type) <u>Jack C Collins</u>		DATE SIGNED <u>3-17-59</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/18/59</u>	22c NAME OF CEMETERY OR CREMATORY <u>MORRIS RIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>DURSEY MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELLERICH FUNERAL HOME - DUNDALK MD</u>		24a REC'D BY REGISTRAR DATE <u>MAR 19 59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

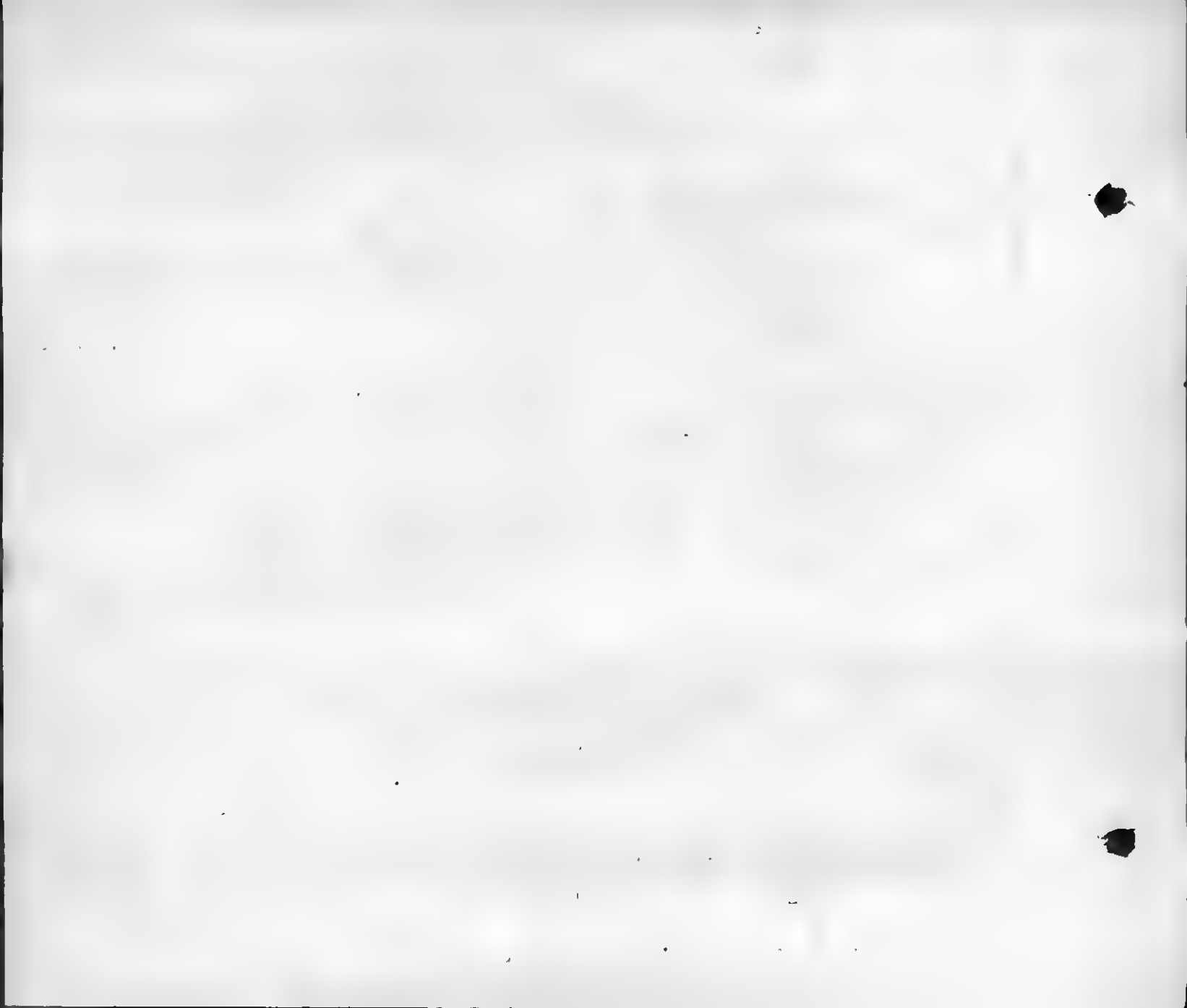
Item 2 Filed 3-16-59 at

CERTIFICATE OF DEATH

Reg. Dist. No.

02765

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr9mth24dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Westminster	
f. STREET ADDRESS Westminster, Maryland		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Haines Last Haines		4. DATE OF DEATH Month March Day 5 Year 19 59	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Keefer		14. MOTHER'S MAIDEN NAME Martha J.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) unk own (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-3465A	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month. Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 23, 1959 to March 5, 1959 , that I last saw the deceased alive on March 5, 1959 , and that death occurred at 5:40a M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-5-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-11-59	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAR 10 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2791

CERTIFICATE OF DEATH

02766

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

BEULAH TRUE HEART HALL

2. DATE
OF
DEATH

March 29, 1959

3. PLACE OF DEATH

A Baltimore City, Maryland Baltimore (12)

4. USUAL RES. DENCE (Where deceased lived If institution residence before admission)

A STATE Maryland B COUNTY 1

D FULL NAME OF (If put in hospital or institution, give street address or location)
HOSPITAL OR BALTIMORE COUNTY
INSTITUTION 246 Blenheim Road

C. C. TY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

6. STREET ADDRESS (If rural, give location)

246 Blenheim Road

c Length of stay in Baltimore

6 yrs

5 SEX

Female

6 COLOR OR RACE

White

7 SINGLE, MARRIED, WIDOWED, OR VORCED (Specify)

Widowed

8 DATE OF BIRTH

Oct 2, 1871

9 AGE (in year last birthday)

87

10 Under 1 Year

11 into Days

12 Under 24 Hours

13 into Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B KIND OF BUSINESS OR INDUSTRY

—

11 PLACE (State or foreign country)

Baltimore

12 CIT. ZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Henry Trueheart

14. MOTHER'S MAIDEN NAME

Lucy White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)

No

(If yes, give war or dates of service)

213-12-6236 D.

SECURITY NO. 213-12-6236

17 INFORMANT

Miss Lucy Bosley Hall

ADDRESS

Same.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(C)

CAUSE OF DEATH

acute cardiac failure

with chronic indurac

at least

INTERVAL BETWEEN ONSET AND DEATH

2 days

3 mos

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A DATE OF OPERATION

19B CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21D TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1 - 1959 to Mar 29 - 1959, that (I) (we) last saw the deceased alive on Mar 24 1959, and that death occurred at 4 A. M., from the causes and on the date stated above.

23A SIGNATURE

Howard J. Warner

23B ADDRESS

2464 Garrison St

23C DATE SIGNED

3-29-59

ATTENDING PHYS. ☒

M.D. DIRECTOR ☐

STAFF PHYS. ☐

24A BURIAL, CREMATION REMOVAL (Specify)

Burial

24B. DATE

March 31, 1959

24C NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D LOCATION (City, town, or county)

Woodlawn Balt. Co. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 31 1959

25. FUNERAL DIRECTOR'S SIGNATURE

H. H. H. H.

25. FUNERAL DIRECTOR

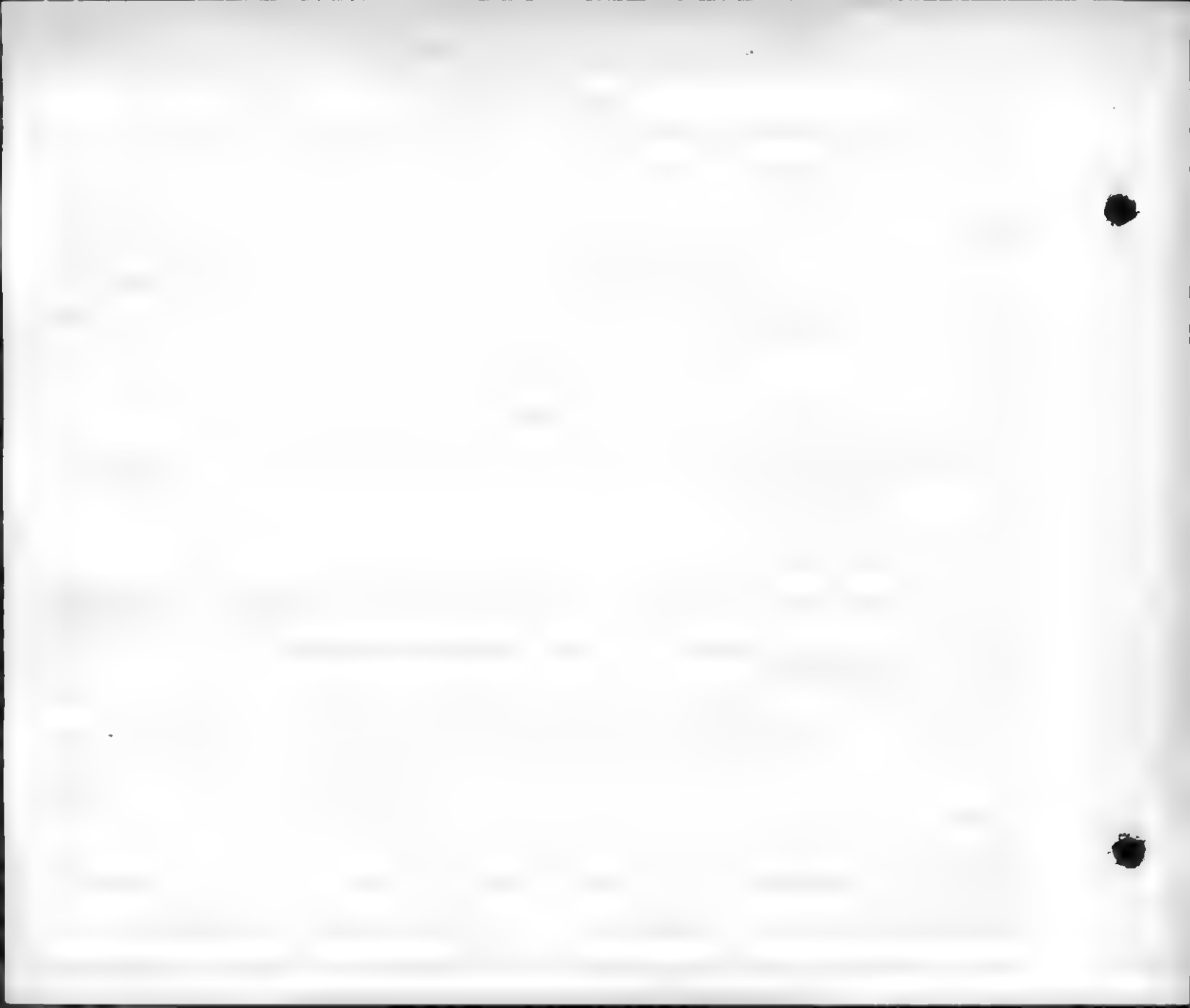
Roberts W. Jenkins & Son Co.

ADDRESS

4905 York R.

THIS IS A PERMANENT RECORD. PLEASE TYPE, IN WITH PERMANENT BLACK OR BLUE-INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2793

CERTIFICATE OF DEATH

02767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perry Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 154 Forge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Preston Middle A. Last Hall		4. DATE OF DEATH Month March Day 3 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1908
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Md. Penitentiary	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Hall		14. MOTHER'S MAIDEN NAME Miranda Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-6633	
17. INFORMANT Mrs. Helen C. Hall		Address 154 Forge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Glomerulonephritis DUE TO Cirrhosis of the Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Glomerulonephritis (c) Cirrhosis of the Liver			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1959 to 3/7, 1959 , that I last saw the deceased alive on 3-5-59 and that death occurred on 2-20-59 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred. Ruzic		ADDRESS (Street, city or town, state) DATE SIGNED 1011 N Charles St Baltimore, Md.	
PHYSICIAN'S NAME (Type) Fred. Ruzic		Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town or county) (State) Fullerton, Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leczek Funeral Home		ADDRESS 7401 Belair Rd	
24a. REC'D BY REGISTRAR MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

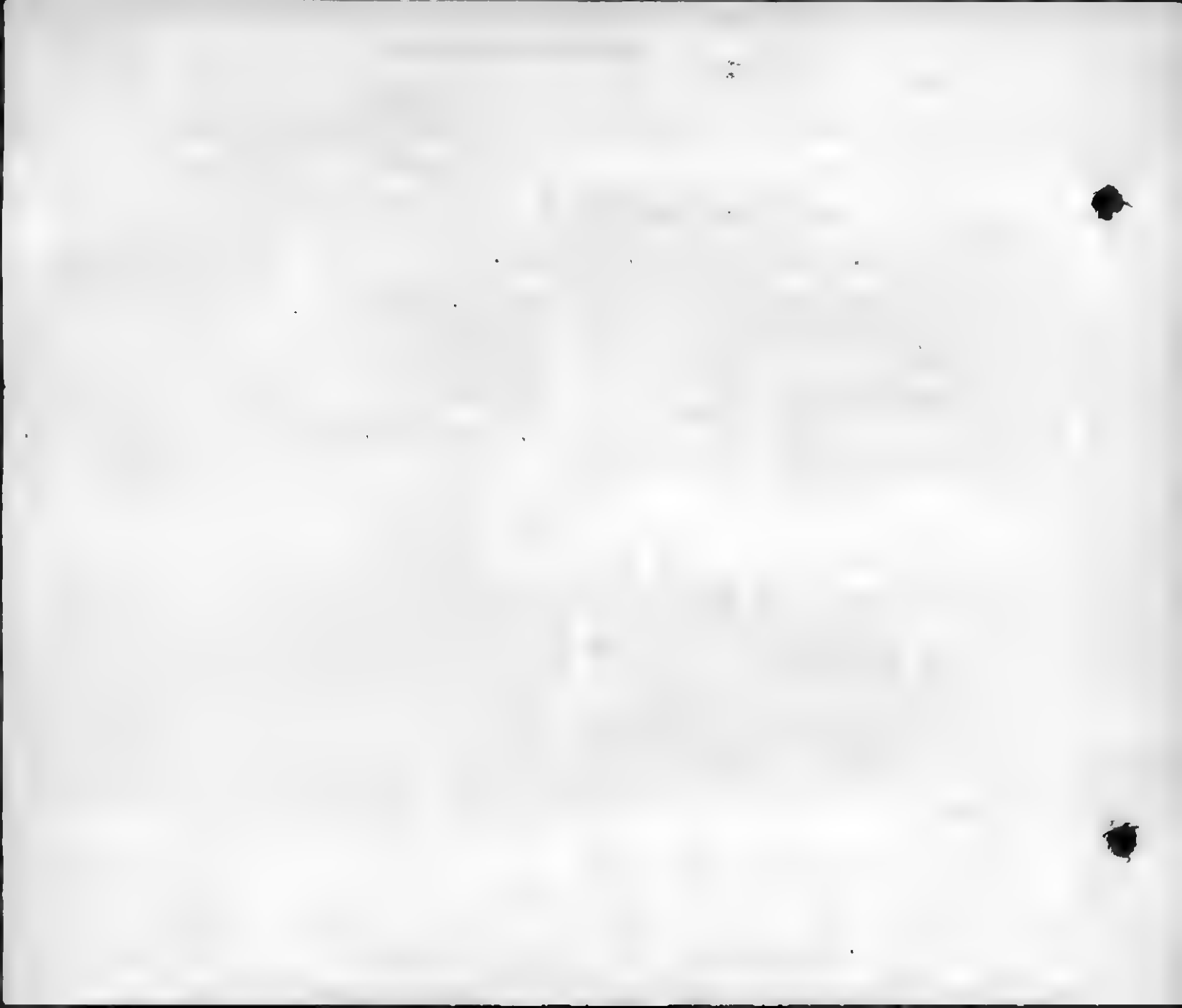
2792
CERTIFICATE OF DEATH

Reg. Dist. No.

02768

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8706 Loch Bend Drive</u>		d. STREET ADDRESS <u>8706 Loch Bend Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Leo Joseph Hebert, Sr.</u>		4. DATE OF DEATH Month Day Year <u>March 7th 19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. FATHER'S NAME <u>John Hebert</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Marie</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Florence Hebert 8706 Loch Bend Dr.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Multiple Arthritis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14- 19 53</u> to <u>Mar 7- 19 59</u> , that I last saw the deceased alive on <u>Jan 14- 19 58</u> , and that death occurred at <u>5 a. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr Lee K Fargo</u> M.D.		ADDRESS (Street, city or town, state) <u>8155 Loch Raven Blvd</u> DATE SIGNED <u>Towson- 4- Md</u>	
PHYSICIAN'S NAME (Type) <u>LEE K FARGO</u>		22a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/ 159</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2795

CERTIFICATE OF DEATH

02770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>76 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. STREET ADDRESS <u>2345 Eutaw Place</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>M</u> Last <u>Henry</u>				4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Henry</u>				14. MOTHER'S MAIDEN NAME <u>Sylvia Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>lymphatic leukemia</u> DUE TO (b) <u>anemia secondary</u> (c) <u>PULMONARY TUBERCULOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1/13</u> , 19 <u>59</u> , to <u>3/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>59</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>William Newcomer</u>				PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u> <u>Superintendent</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ALBANY</u>		22d. LOCATION (City, town, or county) <u>BALTO</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Halstead</u>				ADDRESS <u>918 Spring Hill Ave.</u>		24a. REC'D BY REGISTRAR <u>APR 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

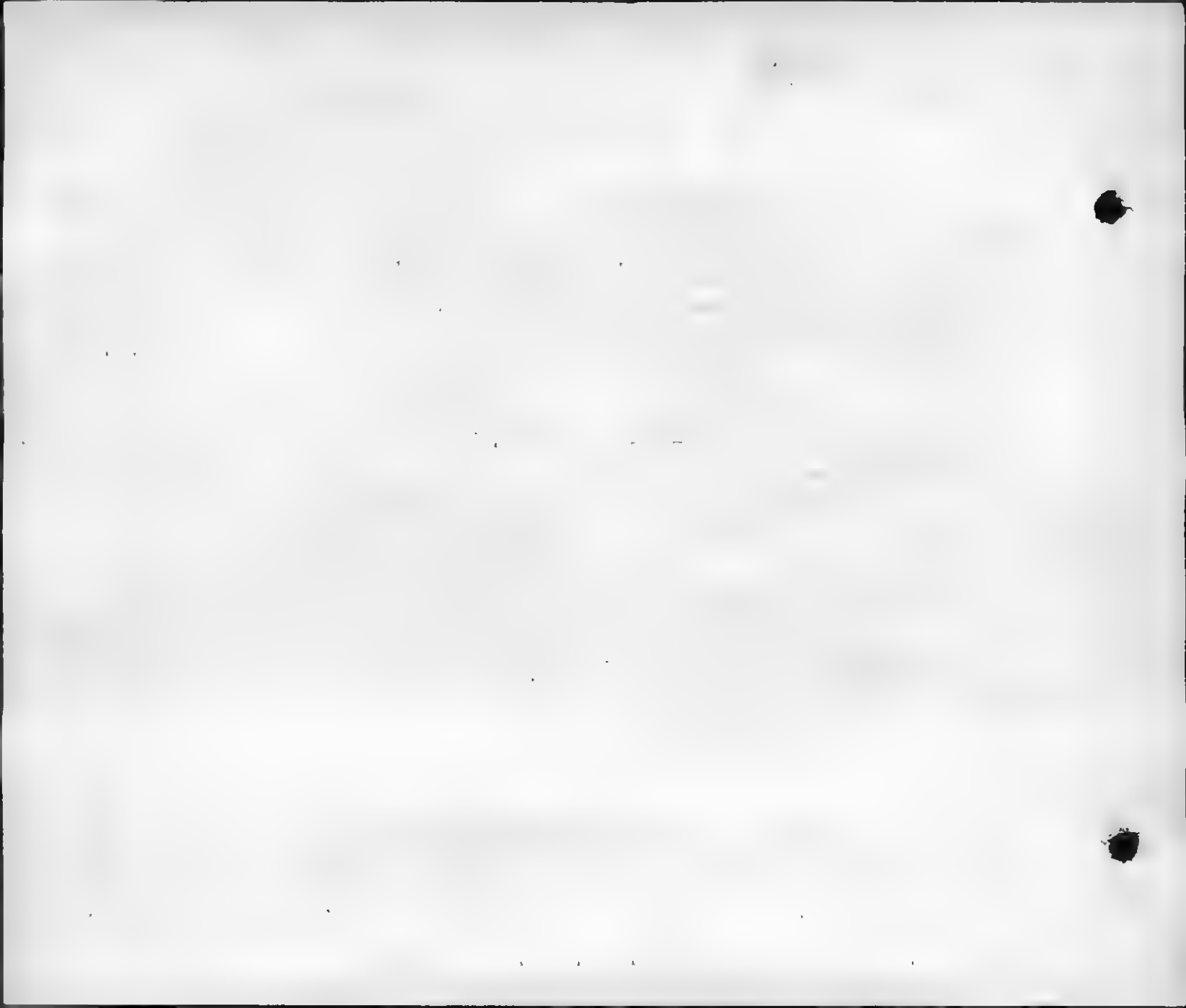
02771

2702

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 198 German Hill Road		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 198 German Hill Road	
3. NAME OF DECEASED (Type or print) Raymond W. Hepner Sr.		4. DATE OF DEATH Month March Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1906
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed Tavern Owner	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Hepner		14. MOTHER'S MAIDEN NAME Madeline ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-07-3557	
17. INFORMANT Mrs. Bertha Hepner		Address 198 German Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO ASCVD Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED No PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 31, 59	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or county) (State) German Hill Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2796

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 7				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 7			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dogwood Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS W. HICKEY</u>				4. DATE OF DEATH Month Day Year <u>March 25 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>John Hickey</u>				14. MOTHER'S MAIDEN NAME <u>Laura Colson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>212-14-9507</u>		17. INFORMANT Address <u>Mrs. Elizabeth Hickey, Baltimore 7, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA-PLADDER - METASTASES</u> <u>18.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 18, 1956</u> to <u>March 25, 1959</u> , that I last saw the deceased alive on <u>MARCH 20, 1959</u> , and that death occurred at <u>3:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>P204 L. BERTY Rd</u> DATE SIGNED <u>3/25/59</u> ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D. <u>EDWIN L. PIERPONT, MD BALTS. 7, Md.</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F.C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2797

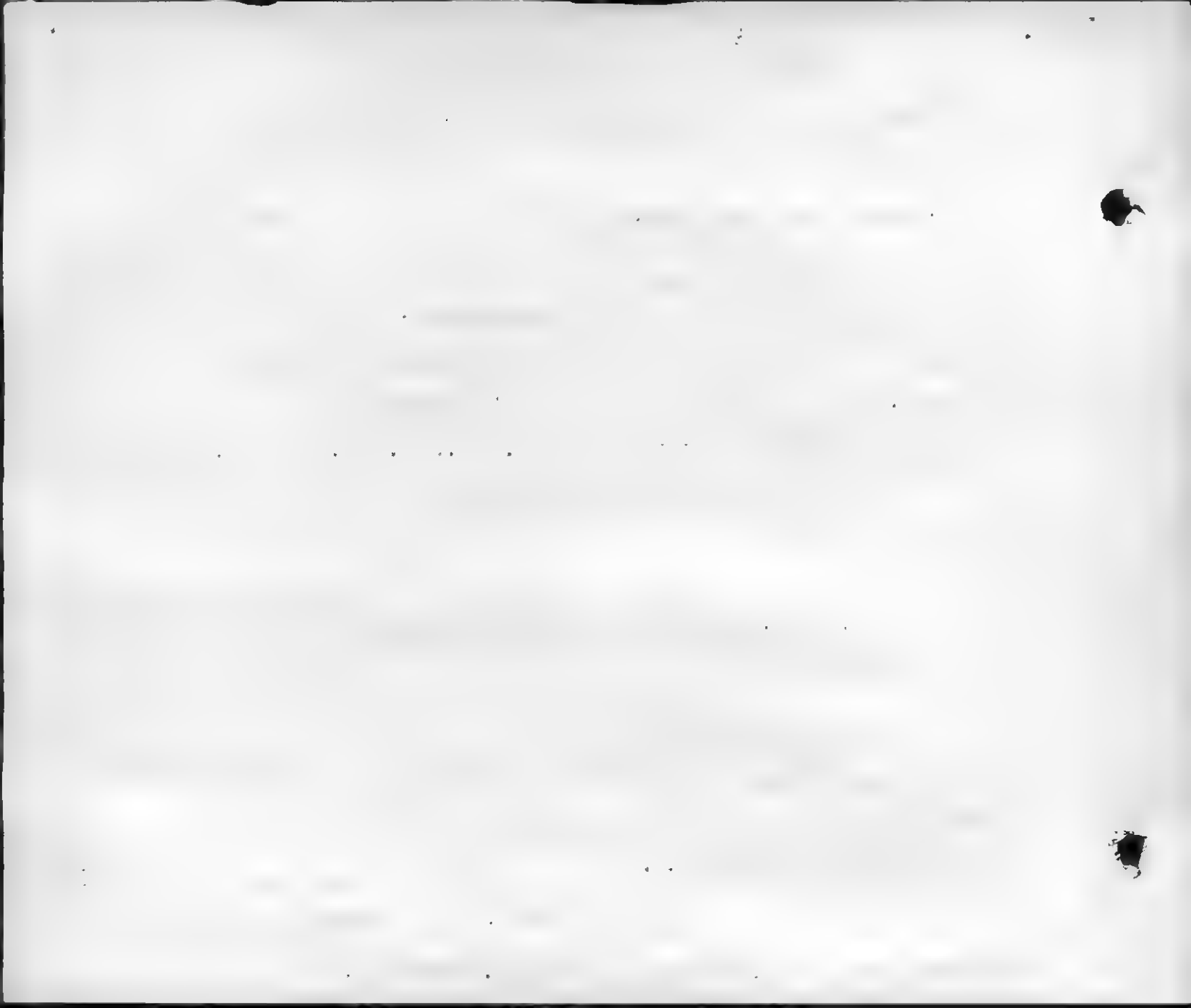
CERTIFICATE OF DEATH

Reg. Dist. No.

02773

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b. COUNTY 1	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First HARRY Middle B Last HICKS		4. DATE OF DEATH Month Marche Day 29 Year 1959	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1888
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR: Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry V. Hicks		14. MOTHER'S MAIDEN NAME Ida Garrity	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4x20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infarction left kidney due to mural thromboses		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27 , 19 59 , to March 29 , 19 59 , and that death occurred at 9:25 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED John W. Crawford M.D. 3/30/59			
ACTUAL SIGNATURE John W. Crawford M.D. 3/30/59			
PHYSICIAN'S NAME (Type) JOHN W CRAWFORD, M.D. VAH FT HOWARD, MD 3/30/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE MacNabb Funeral Home, Frederick & Wade Aves. Catonsville, Md		24a. REC'D BY REGISTRAR APR 2 1959 24b. REGISTRAR'S SIGNATURE Robert S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2798

CERTIFICATE OF DEATH

02774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 6</i>	c. LENGTH OF STAY IN 1b <i>25 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 6</i>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>3820 Joppa Road</i>		d. STREET ADDRESS <i>3820 Joppa Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>ELIZABETH</i> Middle <i>A. HINCHLIFFE</i> Last		4. DATE OF DEATH Month <i>March</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27, 1873</i>
9. AGE (In years last birthday) <i>85 yrs</i>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <i>South Wales</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Mark Bateman</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO (If yes, give war or dates of service) —	17. INFORMANT Charles G. Rule - 4835 B. Home Ave. Phila. Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <i>Advanced myocarditis & arteriosclerosis</i> (c) —			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of uterus.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/15, 1959</i> to <i>3/26, 1959</i> , that I last saw the deceased alive on <i>3/26, 1959</i> , and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>J. Willis Guyton</i>		M.D. <i>3961 Greenmount Ave.</i>	
PHYSICIAN'S NAME (Type) <i>J. Willis Guyton M.D.</i>		<i>Balto. B. Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 2, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hill Side</i>	22d. LOCATION (City, town, or county) (State) <i>Montgomery Co. Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henny H. Jenkins & Sons Co. 4905 York Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles G. Harris</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2799

CERTIFICATE OF DEATH

02775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8104 Harford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary M. Hindle</u>		4. DATE OF DEATH <u>March 17th</u> 19 <u>59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Mary G. Geers,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C-V disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 17, 1955</u> to <u>March 17, 1959</u> that I last saw the deceased alive on <u>March 17, 1959</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Grenzer</u> M.D.		ADDRESS (Street, city or town, state) <u>1520 East 33rd Street</u> DATE SIGNED <u>3/17/59</u>	
PHYSICIAN'S NAME (Type) <u>W. H. GRENZER M.D. Baltimore, 18, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>MAR 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2800

CERTIFICATE OF DEATH

02776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admiss.on) a. STATE <i>MARYLAND</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Samuel</i> First <i>Samuel</i> Middle <i>W.</i> Last <i>Hinkle</i>		4. DATE OF DEATH <i>Feb 14 1959</i> Month <i>Feb</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 18 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stitcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <i>Hinkle</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs. Mildred Hinkle</i> Address <i>Port 86 Bud Lane Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>(1) Cerebral Vascular Accident</i> DUE TO <i>(2) ARTERIOSCLEROSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <i>John E. Gessner</i> attended the deceased from <i>July 3/4</i> , 19 <i>58</i> , to <i>3/4</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3/4</i> , 19 <i>59</i> , and that death occurred at <i>12:28 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John E. Gessner</i>		M D	
PHYSICIAN'S NAME (Type) <i>JOHN E. GESSNER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Mar 4/59</i>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Gessner</i> ADDRESS <i>2024</i>		24a. REC'D BY REGISTRAR <i>MAR 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2801

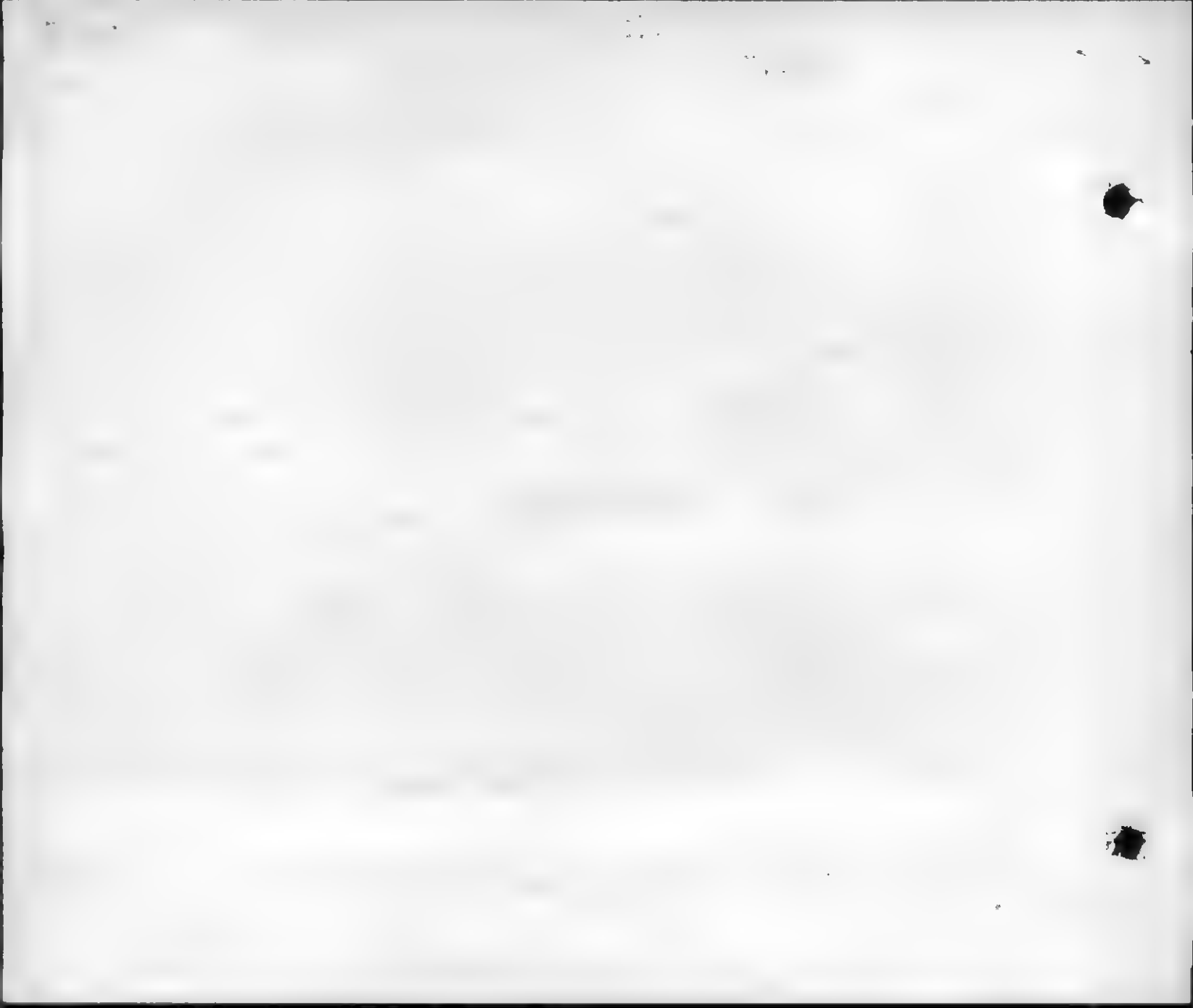
CERTIFICATE OF DEATH

02777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2½ hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 313 N. Robinson Street			
3. NAME OF DECEASED (Type or print) First ALBERT Middle E Last HOCKMAN				4. DATE OF DEATH Month March Day 18 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1900		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver-Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bakery Co		11. BIRTHPLACE (State or foreign country) Batavia, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unknown Hockman				14. MOTHER'S MAIDEN NAME Ellen (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 213-10-9842		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 4 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Post Myocardial Infarction							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7:05 PM March 18, 1959 to 9:35 PM March 18, 1959 , and that death occurred at 9:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>John W. Crawford</i> M.D.				PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 21, 1959		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran Funeral Home 3000 E Balto. St. Balto. Md			
24a. REC'D BY REGISTRAR MAR 23 '59				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 0239 3-16-59 et

2802

CERTIFICATE OF DEATH

02778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dora B. Hoffman</u>				4. DATE OF DEATH <u>March 8, 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/3/1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u> Hours <u>19</u> Min		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
13. FATHER'S NAME <u>Christian Brunnett</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Repborn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NO</u>		17. INFORMANT <u>Dorothy M. Chance</u> Address <u>6305 Mt. Alto Rd. 7</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thin + pneumonia</u> DUE TO <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u></u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/51</u> , 19 <u>51</u> , to <u>3/1/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/7/59</u> , 19 <u>59</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6410 Hunter Mill Rd</u> DATE SIGNED <u>Ballo - 7- med.</u>							
ACTUAL SIGNATURE <u>Milton Scheroff</u>				PHYSICIAN'S NAME (Type) <u>Milton Scheroff</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>				24a. REC'D BY REGISTRAR <u>MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2803

CERTIFICATE OF DEATH

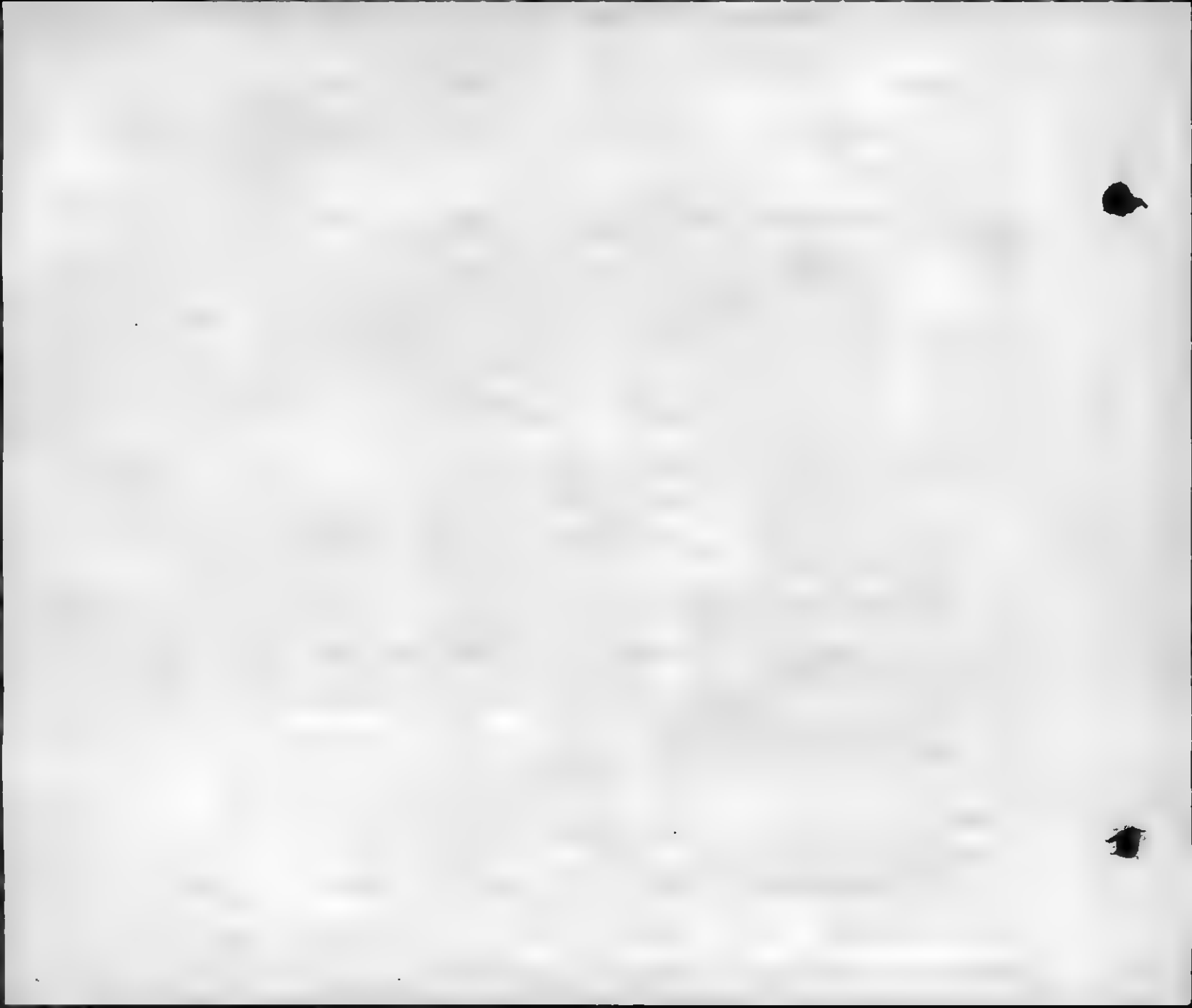
Reg. Dist. No.

02779

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5206 WILKENS AVE</u>		d. STREET ADDRESS <u>5206 WILKENS AVE</u>	
3. NAME OF DECEASED (Type or print) <u>MARIE ELIZABETH HOFMEISTER</u>		4. DATE OF DEATH <u>MARCH 12, 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1886</u>
9. AGE (In years last birthday) <u>72 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AUGUST WERNER</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINE SELIG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CHARLES W. HOFMEISTER</u>		Address <u>5206 WILKENS AVE CATONSVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative C.V. Disease</u> DUE TO <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO (c) <u>2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-30</u> , 19 <u>57</u> , to <u>3-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-12</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Catonville</u> DATE SIGNED <u>3-12</u> ACTUAL SIGNATURE <u>James E. Howell</u> M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LODEN PARK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 16 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

02780

2804

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Butler Rd.		d. STREET ADDRESS 412 Butler Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sadie Middle Elizabeth Last Hohl		4. DATE OF DEATH Month March Day 9 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR: Months 9 Days 9 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lykens, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Helt		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. John Ziegler, 412 Butler Rd., Md.		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Angina Pectoris DUE TO (c) Arteriosclerosis C-V Disease			INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 yrs. 7 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. p. none 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 5-28-52 , 19____, to 3-9-59 , 19____, that I last saw the deceased alive on 3-8-59 , 19____, and that death occurred at 4:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 3-11-59			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 51277		22b. DATE THEREOF 3-12-59	
22c. NAME OF CEMETERY OR CREMATORY WYNNDAIR		22d. LOCATION (City, town, or county) (State) WYNNDAIR 41E	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE LEIMBACH 525 WYNNDAIR STS		24a. REC'D BY REGISTRAR MA'	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MD MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2805

CERTIFICATE OF DEATH

Reg. Dist. No.

02781

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Mace Avenue				d. STREET ADDRESS 204 Mace Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH M. HORMANN				4. DATE OF DEATH Month Day Year MARCH 8, 1959			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 13, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.		12. CITIZEN OF WHAT COUNTRY? US.A.	
13. FATHER'S NAME ADAM BOSZ				14. MOTHER'S MAIDEN NAME MARIE UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO 215 03 3781		17. MARRIAGE MRS JOHN CIESIELSKI Address MRS JAMES OTES 204 MACE AVENUE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 3/8 , 19 59 , to 3/8 , 19 59 , that I last saw the deceased alive on 3/8 , 19 59 , and that death occurred at 8:30 P. from the causes and on the date stated above. 434 Eastern Ave ADDRESS (Street, city or town, state) DATE SIGNED 3/9/59 ACTUAL SIGNATURE J. Platt M.D. 2059 m & . PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/12/59	22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.				
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.			24a. REC'D BY REGISTRAR DATE MAR 10 59	24b. REGISTRAR'S SIGNATURE Charles S. Smith			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2806
CERTIFICATE OF DEATH

02782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rossville		c. LENGTH OF STAY IN 1b X Rossville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 305 Gum Spring Rd.		d. STREET ADDRESS Box 305 Gum Spring Rd.	
3. NAME OF DECEASED (Type or print) Christina M. Huppman		4. DATE OF DEATH Month March Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1901
9. AGE (In years last birthday) 57 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Winkler	
14. MOTHER'S MAIDEN NAME Mary Winkler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address John F. Huppman Box 305 Gum Spring Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Cervix DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 19 59 , to March 28 19 59 , that I last saw the deceased alive on March 28 , 19 59 , and that death occurred at 4 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G.M. Baumgardner		DATE SIGNED 3/30/59	
PHYSICIAN'S NAME (Type) G.M. Baumgardner		ADDRESS (Street, city or town, state) Baltimore Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-1-1959	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lessah Funeral Home		24a. REC'D BY REGISTRAR APR 1 '59	
ADDRESS 7401 Belair Rd		24b. REGISTRAR'S SIGNATURE Christina S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

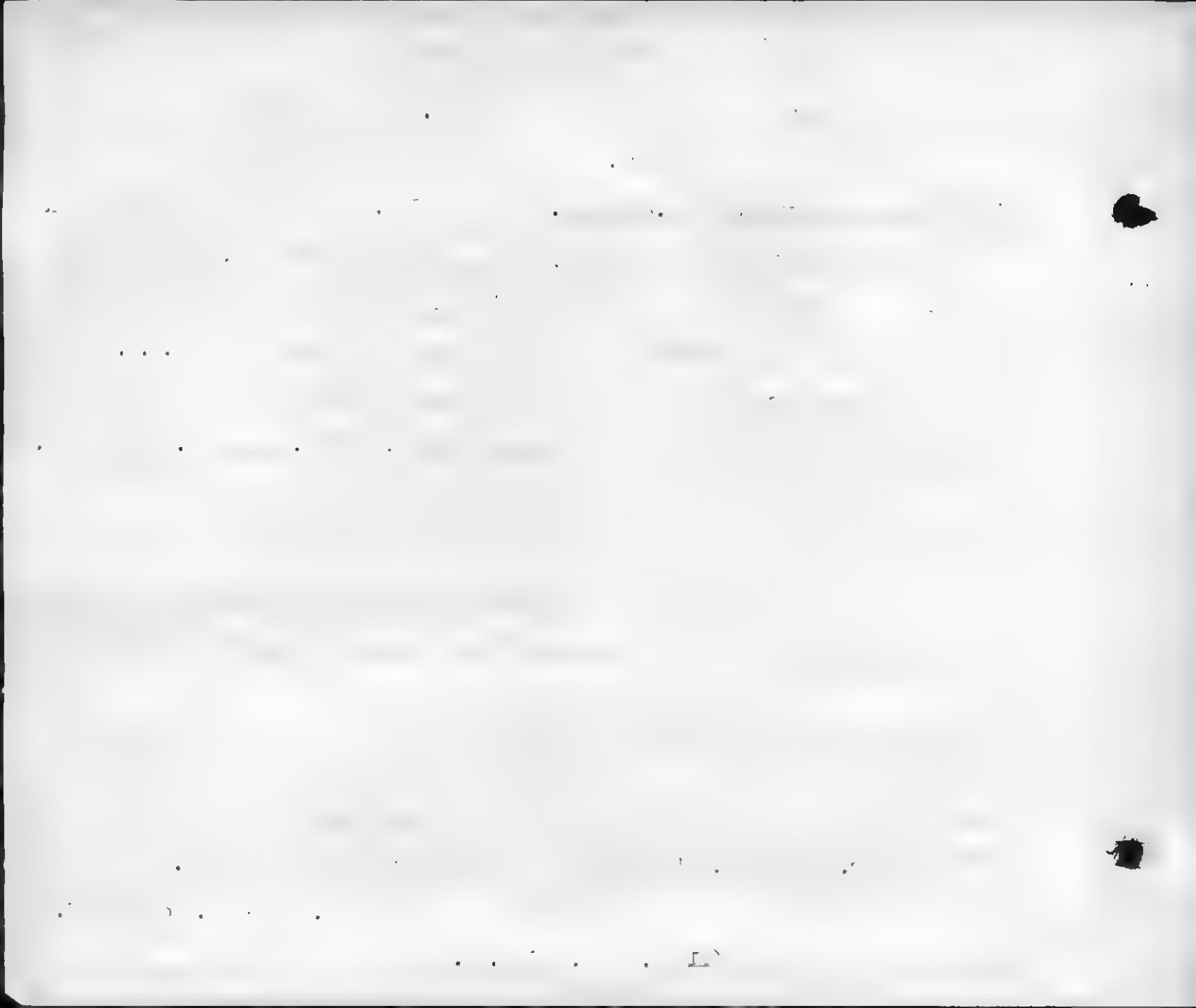
02783

2807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent, 1001 W. Joppa Rd.		d. STREET ADDRESS 1001 W. Joppa Road	
3. NAME OF DECEASED (Type or print) Sister Mary Ancilla (Hurley)		4. DATE OF DEATH March 20, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1878
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	
11. BIRTHPLACE (State or foreign country) Wellsburg, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Hurley		14. MOTHER'S MAIDEN NAME Mary McCarthy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Rd. Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Miliary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 wks (c) 2 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1950, to March 20, 1959 , that I last saw the deceased alive on March 3, 1959 , and that death occurred at 2:37 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell		ADDRESS (Street, city or town, state) 7501 York Road	
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		DATE SIGNED 3/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/59	
22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Vernon Lemmon		ADDRESS 4612 Pk. Hgts. Balto. Md.	
24a. REC'D BY REGISTRAR MAR 23 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2808

CERTIFICATE OF DEATH

Reg. Dist. No.

02784

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First French Middle Wilbert Last Hylton		4. DATE OF DEATH Month March Day 27 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-99
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 M.n. 59	IF UNDER 24 HRS Months 59 Days 59 Hours 59 M.n. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Mine	
11. BIRTHPLACE (State or foreign country) W. Va		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Peter Hylton		14. MOTHER'S MAIDEN NAME Ossie Aleff OCCIE ALIFF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO 232-165791	
17. INFORMANT Personal History		Address Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal disease / Tuberculosis DUE TO (b) SILICOTUBERCULOSIS DUE TO (c) 001 X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 11, 1956 to March 27, 1959 , that I last saw the deceased alive on March 27, 1959 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eudowood Sanatorium, Towson 4, Md. DATE SIGNED March 27, 1959			
ACTUAL SIGNATURE Milton B. Kress, M.D.			
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		24a. REC'D BY REGISTRAR DATE APR 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kress			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

131

132

133

134

135

136

137

138

139

140

141

142

143

144

145

146

147

148

149

150

151

152

153

154

155

156

157

158

159

160

161

162

163

164

165

166

167

168

169

170

171

172

173

174

175

176

177

178

179

180

181

182

183

184

185

186

187

188

189

190

191

192

193

194

195

196

197

198

199

200

201

202

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

219

220

221

222

223

224

225

226

227

228

229

230

231

232

233

234

235

236

237

238

239

240

241

242

243

244

245

246

247

248

249

250

251

252

253

254

255

256

257

258

259

260

261

262

263

264

265

266

267

268

269

270

271

272

273

274

275

276

277

278

279

280

281

282

283

284

285

286

287

288

289

290

291

292

293

294

295

296

297

298

299

300

301

302

303

304

305

306

307

308

309

310

311

312

313

314

315

316

317

318

319

320

321

322

323

324

325

326

327

328

329

330

331

332

333

334

335

336

337

338

339

340

341

342

343

344

345

346

347

348

349

350

351

352

353

354

355

356

357

358

359

360

361

362

363

364

365

366

367

368

369

370

371

372

373

374

375

376

377

378

379

380

381

382

383

384

385

386

387

388

389

390

391

392

393

394

395

396

397

398

399

400

401

402

403

404

405

406

407

408

409

410

411

412

413

414

415

416

417

418

419

420

421

422

423

424

425

426

427

428

429

430

431

432

433

434

435

436

437

438

439

440

441

442

443

444

445

446

447

448

449

450

451

452

453

454

455

456

457

458

459

460

461

462

463

464

465

466

467

468

469

470

471

472

473

474

475

476

477

478

479

480

481

482

483

484

485

486

487

488

489

490

491

492

493

494

495

496

497

498

499

500

501

502

503

504

505

506

507

508

509

510

511

512

513

514

515

516

517

518

519

520

521

522

523

524

525

526

527

528

529

530

531

532

533

534

535

536

537

538

539

540

541

542

543

544

545

546

547

548

549

550

551

552

553

554

555

556

557

558

559

560

561

562

563

564

565

566

567

568

569

570

571

572

573

574

575

576

577

578

579

580

581

582

583

584

585

586

587

588

589

590

591

592

593

594

595

596

597

598

599

600

601

602

603

604

605

606

607

608

609

610

611

612

613

614

615

616

617

618

619

620

621

622

623

624

625

626

627

628

629

630

631

632

633

634

635

636

637

638

639

640

641

642

643

644

645

646

647

648

649

650

651

652

653

654

655

656

657

658

659

660

661

662

663

664

665

666

667

668

669

670

671

672

673

674

675

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

704

705

706

707

708

709

710

711

712

713

714

715

716

717

718

719

720

721

722

723

724

725

726

727

728

729

730

731

732

733

734

735

736

737

738

739

740

741

742

743

744

745

746

747

748

749

750

751

752

753

754

755

756

757

758

759

760

761

762

763

764

765

766

767

768

769

770

771

772

773

774

775

776

777

778

779

780

781

782

783

784

785

786

787

788

789

790

791

792

793

794

795

796

797

798

799

800

801

802

803

804

805

806

807

808

809

810

811

812

813

814

815

816

817

818

819

820

821

822

823

824

825

826

827

828

829

830

831

832

833

834

835

836

837

838

839

840

841

842

843

844

845

846

847

848

849

850

851

852

853

854

855

856

857

858

859

860

861

862

863

864

865

866

867

868

869

870

871

872

873

874

875

876

877

878

879

880

881

882

883

884

885

886

887

888

889

890

891

892

893

894

895

896

897

898

899

900

901

902

903

904

905

906

907

908

909

910

911

912

913

914

915

916

917

918

919

920

921

922

923

924

925

926

927

928

929

930

931

932

933

934

935

936

937

938

939

940

941

942

943

944

945

946

947

948

949

950

951

952

953

954

955

956

957

958

959

960

961

962

963

964

965

966

967

968

969

970

971

972

973

974

975

976

977

978

979

980

981

982

983

984

985

986

987

988

989

990

991

992

993

994

995

996

997

998

999

1000



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2810
CERTIFICATE OF DEATH

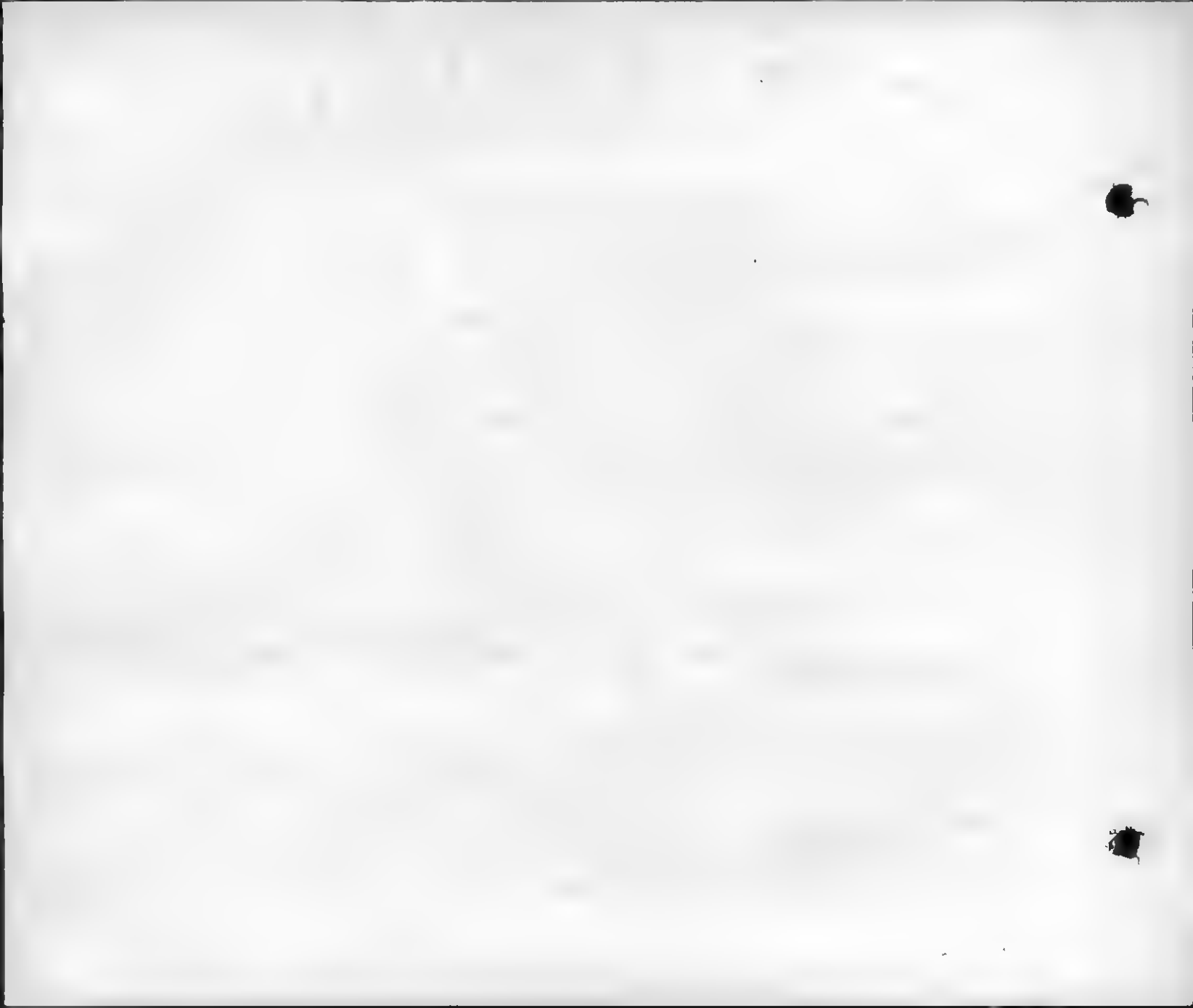
Reg. Dist. No.

02786

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>13a/10</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6507 Gilmore Ave</u>		e. STREET ADDRESS <u>6507 Gilmore Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond E.</u> Middle <u>Jackson</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21, 1916</u>
9. AGE (In years last birthday) <u>43 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Index Stationary</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Fox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-039886</u>	
17. INFORMANT <u>Mrs. Catherine Jackson</u>		Address <u>6507 Gilmore Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a</u> m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/16/59</u> , 19 <u>59</u> , to <u>3/17/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/16/59</u> , 19 <u>59</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6410 W. Windsor Mill Rd.</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Milton Schlenker</u> M.D. <u>6410 W. Windsor Mill Rd.</u>			
PHYSICIAN'S NAME (Type) <u>Milton Schlenker</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 having been detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2717

CERTIFICATE OF DEATH

Reg. Dist. No. 02787

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne 51			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3109 Virginia Avenue				d. STREET ADDRESS 3109 Virginia Avenue #27			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOHN First GABRIEL Middle JANUSKA Last			4. DATE OF DEATH Month March Day 23 Year 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1877		9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO Yes		17. INFORMANT Address Mr. Charles Januska-3109 Virginia Avenue #27			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerosis & old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis & old age DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 to 3.23.1959 , that I last saw the deceased alive on 3.23.1959 , and that death occurred at 1140 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1802 W. Balt St DATE SIGNED Balt 23 Md							
ACTUAL SIGNATURE Stanley Ankudas M.D.			PHYSICIAN'S NAME (Type) STANLEY ANKUDAS				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/27/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckew				ADDRESS Balto 17, Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02788

2811

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b X Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7404 Belair Rd.		d. STREET ADDRESS 7404 Belair Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha M. Jasper		4. DATE OF DEATH Month Day Year March 8, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1886
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME William A. Green	
14. MOTHER'S MAIDEN NAME Mary Wurzbacher		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO 218-32-1631		17. INFORMANT Charles A. Jasper Address 4116 Taylor Ave. 6	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extension of Pontine Angle Thrombosis - Cerebral 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pontine Angle Thrombosis - Cerebral DUE TO (c) Atherosclerotic Cardiovascular Disease Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction. Malnutrition. Endogenous & Anemia		INTERVAL BETWEEN ONSET AND DEATH 2-3 days approx 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-29, 1957, to 3-8, 1959 , that I last saw the deceased alive on 3-7, 1959 , and that death occurred at 6:15 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 7527 Belair Rd Balto 6 DATE SIGNED 3-9-59			
ACTUAL SIGNATURE John C. Hyle		M.D. 7527 Belair Rd Balto 6	
INTERMEDIATE NAME (Type) JOHN C. Hyle			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 11, 1959	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lillian Funeral Home		ADDRESS 7404 Belair Rd.	
24a. REC'D BY REGISTRAR MAR 11 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Hance	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02789

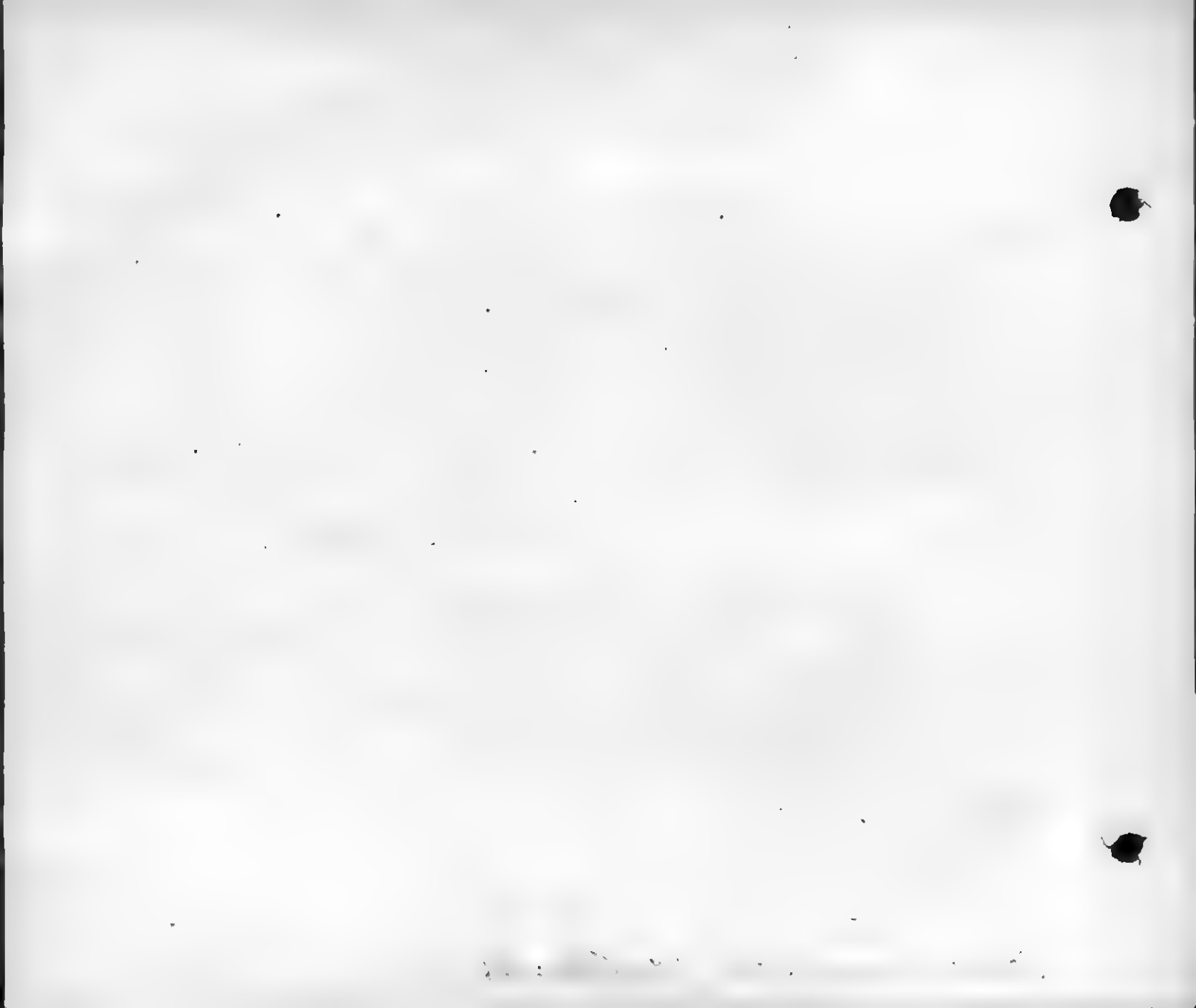
2812

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7541 Belair Rd.				d. STREET ADDRESS 7541 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie		First Middle Last Jones		4. DATE OF DEATH Month Day Year March 2, 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1889		9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Henry Hartman				14. MOTHER'S MAIDEN NAME Unknown Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Rocco Citro 7541 Belair Rd. 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Degeneration</i>							
4 DUE TO <i>Cardiac Failure</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Advanced</i>							
(c) <i>Advanced Generalized Degenerative changes.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Endogenous Malnutrition and Generalized muscle wasting.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>MAY</i> , 1956, to <i>2 Mar</i> , 1959, that I last saw the deceased alive on <i>1 Mar</i> , 1958, and that death occurred at <i>9 AM</i> , from the causes and on the date stated above							
ACTUAL SIGNATURE <i>John C. Hyle</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>JOHN C. HYLE</i> <i>7541 Belair Rd. Balt. Md.</i>			
PHYSICIAN'S NAME (Type) 7541 Belair Rd							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-1959		22c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		22d. LOCATION (City, town or county) (State) Belair, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewahn Funeral Home</i>				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE <i>MAR 6 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02790

Reg. Dist. No.

2703

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2363 Charles Rd. Balto. 22				d. STREET ADDRESS 2363 Charles Rd. 22			
3. NAME OF DECEASED (Type or print) First VOS Middle KAMPEAN Last				4. DATE OF DEATH Month MARCH Day 22 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-85		9. AGE (in years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Austria, Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Kampean				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-07-4358		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-25-59		22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly				ADDRESS 418 Center St.		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enter date of certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2813

CERTIFICATE OF DEATH

Reg. Dist. No.

02791

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 25yr7mth25ays			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle R. Last Kane				4. DATE OF DEATH Month March Day 10 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28, 1879	
9. AGE (In years last birthday) yrs 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Starch				14. MOTHER'S MAIDEN NAME Margaret Manger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 18, 1959 , to March 10, 1959 , that I last saw the deceased alive on March 10, 1959 , and that death occurred at 6 A. M. from the causes and on the date stated above							
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-10-59					
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hubbard Furn. Home, 4107 Wilkens Ave.				ADDRESS Balto., Md.		24a. REC'D BY REGISTRAR DATE MAR 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2718

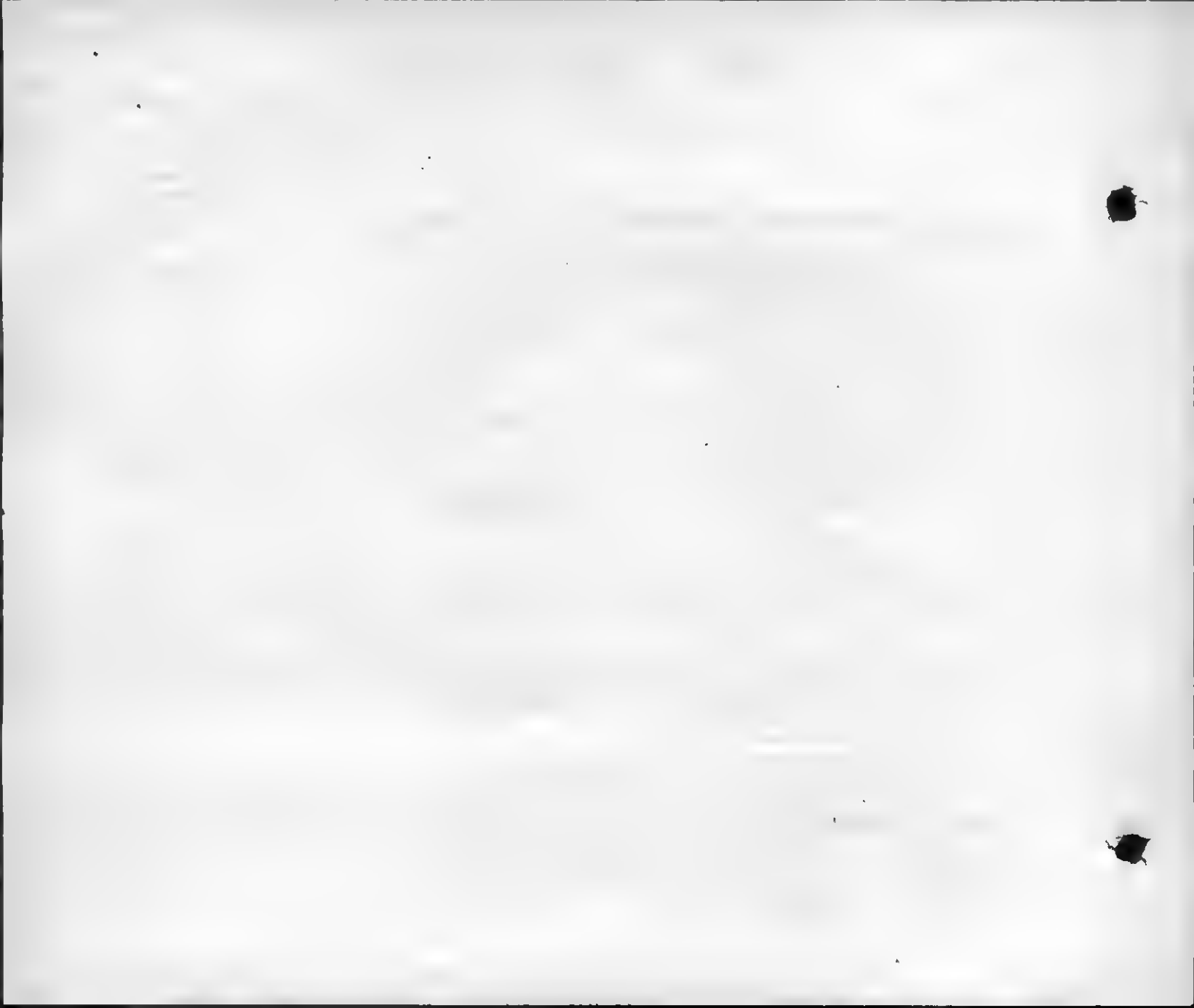
CERTIFICATE OF DEATH

Reg. Dist. No.

02792

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1216 LEEDS TERRACE		d. STREET ADDRESS 1216 LEEDS TERRACE	
3. NAME OF DECEASED (Type or print) First Middle Last AUGUST KAZLAUSKI SR.		4. DATE OF DEATH Month Day Year 3/9/59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 23, 1886
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Europe		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Matthew Kazlauski		14. MOTHER'S MAIDEN NAME Mary (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 01 8793	
17. INFORMANT Nellie Kazlauski		Address 1216 Leeds Terrace 27	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of the Rectum 154X DUE TO metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 8, 1959 , to March 9, 1959 , that I last saw the deceased alive on March 8, 1959 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John T. Coolsen		ADDRESS (Street, city or town, state) 4201 WILKENS AVE BALTIMORE 29, MD	
DATE SIGNED 3/12/59			
22a. BURIAL CREMATION, REMOVAL (Type or print) Burial		22b. DATE THEREOF 3/13/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	
24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2719

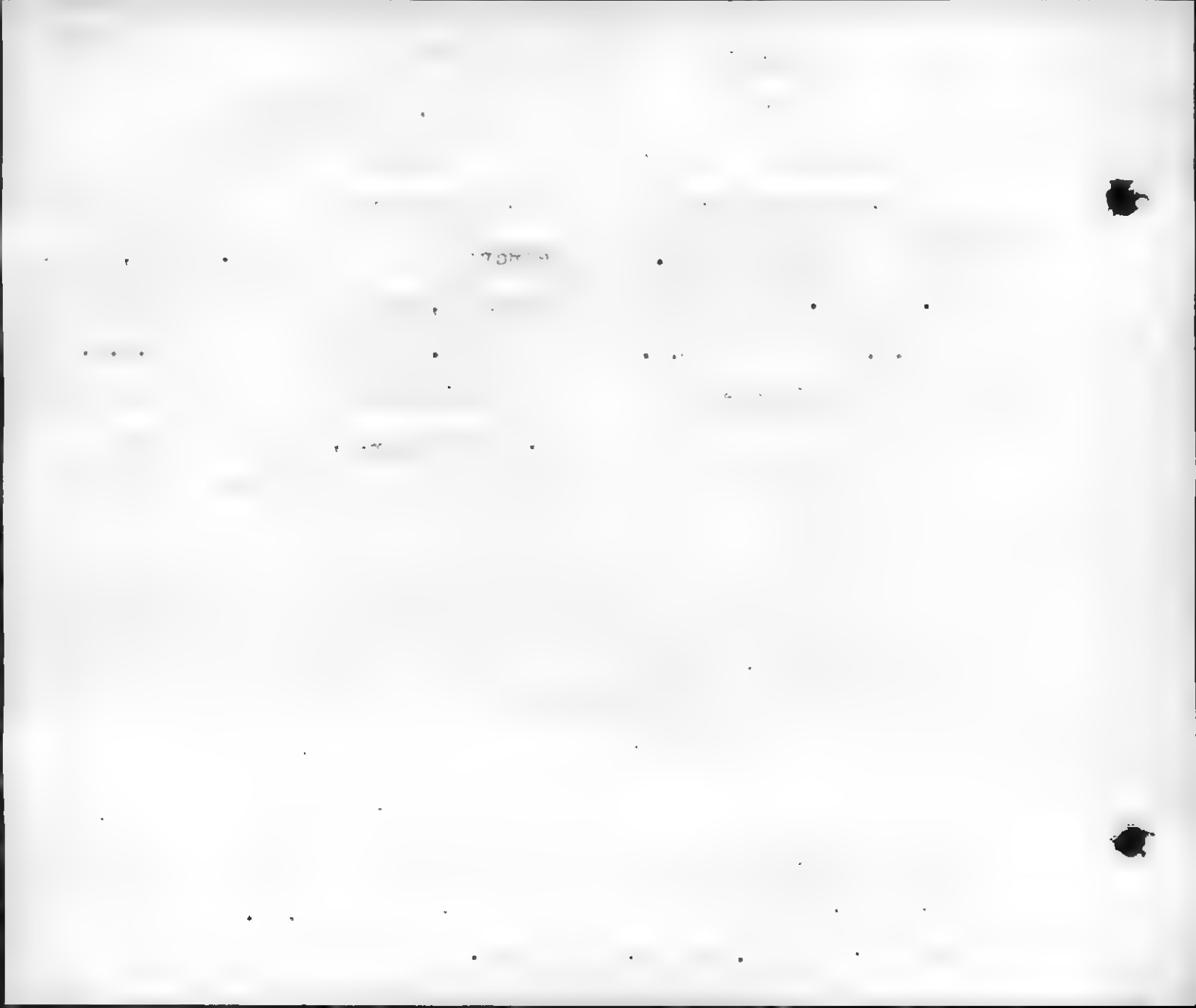
CERTIFICATE OF DEATH

Reg. Dist. No.

02793

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b Life		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4410 Hooper Ave		e. STREET ADDRESS 4410 Hooper Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Esther M. Keeney		4. DATE OF DEATH Month Day Year Mar. 11, 1959			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1907	9. AGE (In years last birthday) yrs 51	IF UNDER 1 YEAR Months Days Hours Min. 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Philip Braoh		14. MOTHER'S MAIDEN NAME Alice White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		INFORMANT Address Mr. Grafton Keeney, 4410 Hooper Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Bronchogenic Carcinoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1958 to March 11, 1959 that I last saw the deceased alive on March 10, 1959 and that death occurred at 9:00 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 206 S. Gilmore St 3.11.59					
ACTUAL SIGNATURE Nathan Racusin		M.D. 206 S. Gilmore St			
PHYSICIAN'S NAME (Type) NATHAN RACUSIN		1311 to 23 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
22d. LOCATION (City, town, or county) (State) Balto. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE MAR 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

02794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN TB 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3421 Dunran Road		d. STREET ADDRESS 3421 Dunran Road	
3. NAME OF DECEASED (Type or print) First KENDRED ABEL Middle KELLUM Last		4. DATE OF DEATH Month March Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Kellum	
14. MOTHER'S MAIDEN NAME Sadie Kirby		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 218-01-1532		17. INFORMANT Mrs. Amelia Kellum Address 3421 Dunran Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease with failure.			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1957 to March 1959 , that I last saw the deceased alive on 3-3 , 19 59 , and that death occurred at 4 p. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M. D.		ADDRESS (Street, city or town, state) 6801 Belair Rd	
PHYSICIAN'S NAME (Type) Wyman K Wong		DATE SIGNED Balto. 6. Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.	22d. LOCATION (City, town, or county) (State) Fountain Green, Harford Co.
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC.		24a. REC'D BY REGISTRAR MAR 18 '59	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2814

CERTIFICATE OF DEATH

02795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - GRANITE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - GRANITE</u>			
c. LENGTH OF STAY IN 1b <u>35 YEARS</u>				d. STREET ADDRESS <u>OFFUTT RD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OFFUTT RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>DUFF</u> Last <u>KEMP</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6, 1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>15</u> Min.	IF UNDER 24 HRS Months <u>7</u> Days <u>11</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB KEMP</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-40-5978</u>		17. INFORMANT <u>WIFE - MRS. MATTIE C KEMP</u> Address <u>OFFUTT RD GRANITE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS.</u> DUE TO (c) <u>CORONARY ARTERY DISEASE</u> <u>EMPHYSEMA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>1 YEAR, 15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 16, 1952</u> to <u>MARCH 25, 1959</u> , that I last saw the deceased alive on <u>MARCH 23, 1959</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin Pierpont</u>				ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, MD.</u>				DATE SIGNED <u>3/25/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Poplar Springs Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				24a. REC'D BY REGISTRAR <u>8728 Liberty Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 240 3-1-59 at

2815

CERTIFICATE OF DEATH

02796

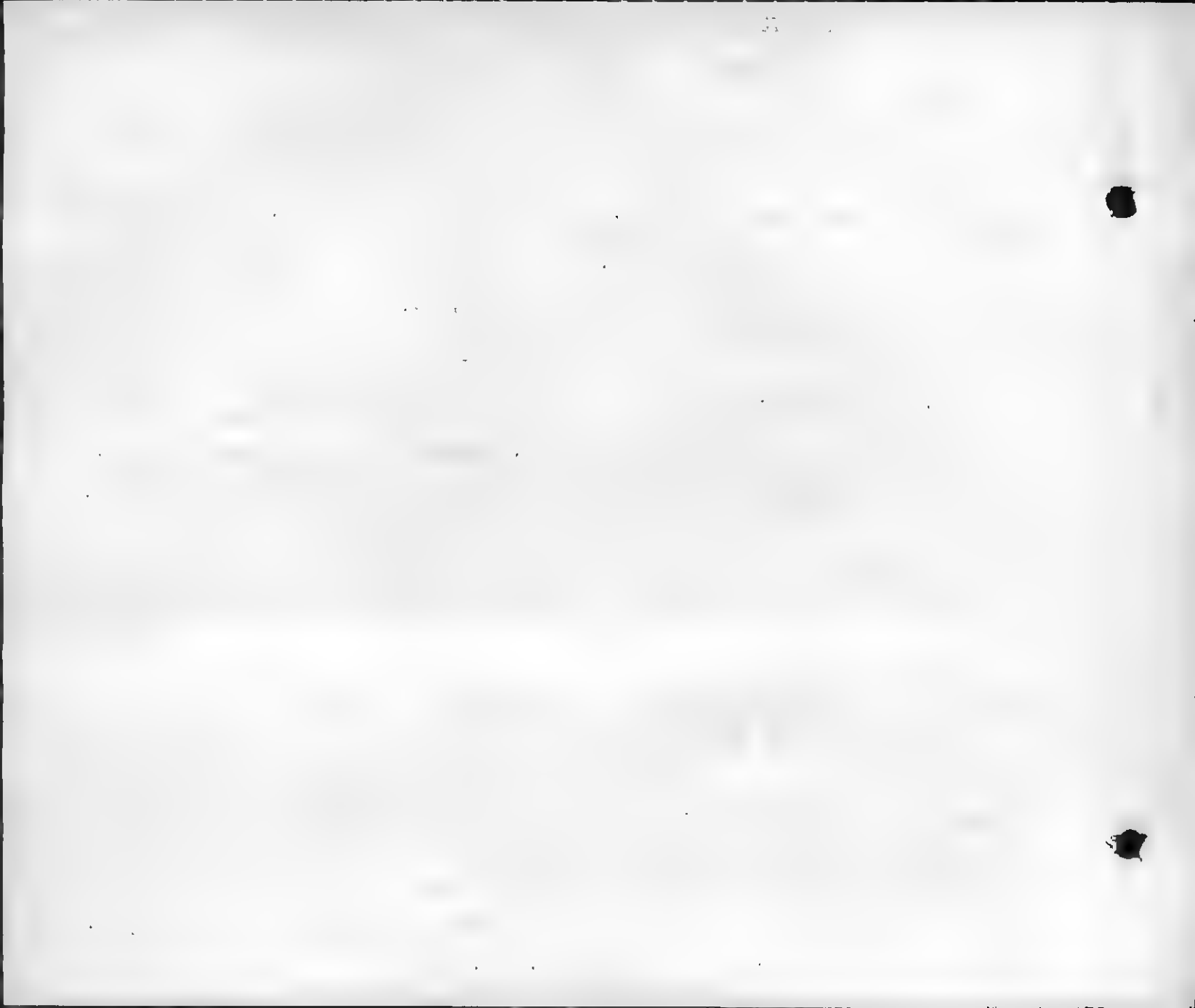
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3525 Meadowside Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 d. STREET ADDRESS 3525 Meadowside Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle A. Last KENNARD		4. DATE OF DEATH Month March Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 16, 1977
9. AGE (In years last birthday) yrs 81		10. IF UNDER 1 YEAR Months 1 Days 13 Hours 13 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Altoona, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Fred Bitzberger		14. MOTHER'S MAIDEN NAME Elizabeth Emfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Jessie Frey-3525 Meadowside Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) advanced arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH about 1 hr 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 20 , 19 59 , to March 13 , 19 59 , that I last saw the deceased alive on March 13 , 19 59 , and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4508 N. Charles St DATE SIGNED March 17, 1959			
ACTUAL SIGNATURE Walter H. Smith		M.D. Walter H. Smith	
PHYSICIAN'S NAME (Type) Walter H. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/16/1959	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR DATE MAR 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Francis			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2816

CERTIFICATE OF DEATH

02797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN TB 4 YEARS-7mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
f. STREET ADDRESS 8004 PHILADELPHIA ROAD				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OLIVER Middle THOMAS Last KENNEY				4. DATE OF DEATH Month MARCH Day 25 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-24-1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 9 Hours 15 Min.		IF UNDER 24 HRS Months 7 Days 9 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY PRODUCE BUSINESS		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S							
13. FATHER'S NAME OLIVER J. KENNEY				14. MOTHER'S MAIDEN NAME KATE HESS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Frank L. Smith Jr. Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio							3 years
DUE TO (b) Vascular Disease							
DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-26, 1958 , to 3-25, 1959 , that I last saw the deceased alive on 3-25, 1959 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur L. Kues				ADDRESS (Street, city or town, state) Cockeysville, Md.			
DATE SIGNED 3/25/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-28-59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kues	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 1, 2, & 12. Film G240, 3/23/59 icy

2817

CERTIFICATE OF DEATH

02798

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 98 Smithwood Ave., Catonsville				c. LENGTH OF STAY IN 1b 14 Old Court Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summitt Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HUGH Middle F. Last KERR				4. DATE OF DEATH Month 3 Day 13 Year 59			
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH	
9. AGE (In years last birthday) 86 (1)		IF UNDER 1 YEAR Months 1 Days 19		IF UNDER 24 HRS Hours 19 Min 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Clerk				10b. KIND OF BUSINESS OR INDUSTRY ?		11 BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? United States							
13 FATHER'S NAME Unknown				14 MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no -				16. SOCIAL SECURITY NO -			
17 INFORMANT Mrs. Constance F. Kerr-7309 York Rd.				Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o m 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Mar 19 59 to 13 Mar 19 59 , that I last saw the deceased alive on 12 Mar 19 59 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. McGreth		M.D. 1303 Frederick Rd		ADDRESS (Street, city or town, state) Catonsville 28md		DATE SIGNED 3/13/59	
PHYSICIAN'S NAME (Type) W. E. McGreth							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/14/59		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		22d. LOCATION (City, town, or county) (State) Baltimore	
23 FUNERAL DIRECTOR'S SIGNATURE WIEDEFELD & SON				ADDRESS 501 E. 22nd St.		24a. REC'D BY REGISTRAR MAR 16 59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02799

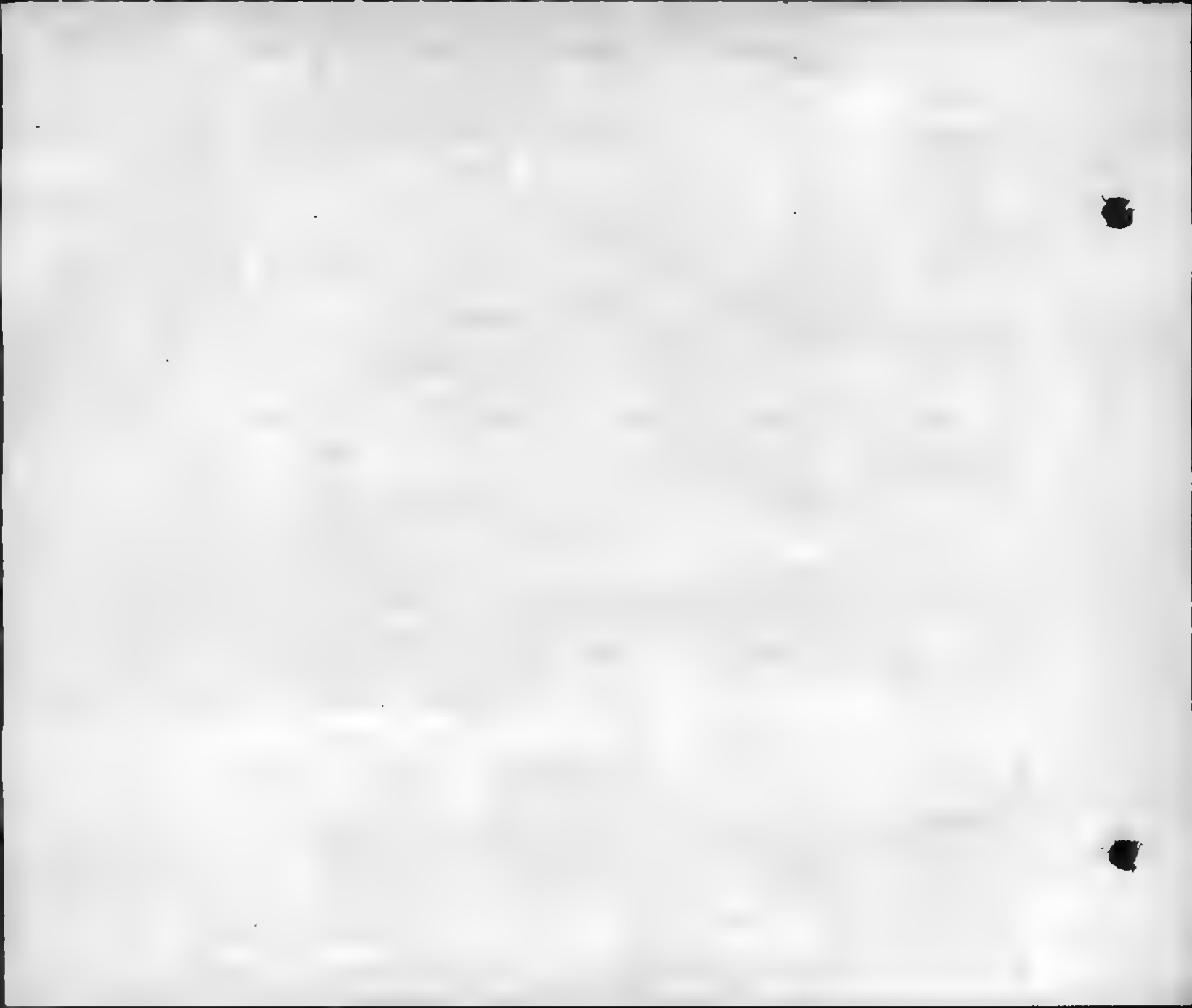
Reg. Dist. No.

2705

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>205 Detroit Ave.</u>				d. STREET ADDRESS <u>205 Detroit Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSBIE ERVIN KIRK</u>				4. DATE OF DEATH Month Day Year <u>March 29, 19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 16, 1887</u>		9. AGE (in years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Signal Corps.</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Kirk</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Whitwell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Lula Kirk 205 Detroit Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) </div> <div style="width: 25%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>2 years</u> </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Jack C Collins</u> EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>April 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Medaw Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>						24a. REC'D BY REGISTRAR <u>MAR 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.



2813

CERTIFICATE OF DEATH

02800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>812 E. STREET</u>		d. STREET ADDRESS <u>1812 E. STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA W. KIRSHNER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 25 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 9, 1875</u>
9. AGE (in years last birthday) <u>83 yrs</u>		10. FUNERAL YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM WILD</u>		14. MOTHER'S MAIDEN NAME <u>DON'T KNOW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>JOHN W. REID 812 E ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Arteriosclerosis H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19, 1954</u> to <u>May 25, 1959</u> , that I last saw the deceased alive on <u>Mar 25, 1959</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Means</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>520 DIST. BALTIMORE 3/25/59</u>	
PHYSICIAN'S NAME (Type) <u>James T. Means</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>3/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM</u>	22d. LOCATION (City, town, or county) (State) <u>ROANOKE VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME 2112 DUNDON</u>		24a. REC'D BY REGISTRAR <u>MAR 30 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur B. Knapp</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2819

CERTIFICATE OF DEATH

02801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>4 ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>431 LORRAINE AVE. (21)</u>		d. STREET ADDRESS <u>1431 LORRAINE AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD DUNCAN KNIGHT</u>		4. DATE OF DEATH Month Day Year <u>MAR 26 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Con. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN KNIGHT</u>		14. MOTHER'S MAIDEN NAME <u>ELLA DUNCAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Circulatory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Heart failure, chronic</u> (c) DUE TO <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET OF DEATH <u>6 hours</u> <u>more than 4 weeks</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes melitus, - Cerebral hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>— 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>—</u>		(County) <u>—</u>
20g. (State) <u>—</u>		
21. I certify that I attended the deceased from <u>June 2, 1955</u> to <u>March 26, 1959</u> , that I last saw the deceased alive on <u>March 26, 1959</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Eugene C. Bannan</u> M.D.		DATE SIGNED <u>413 Eastern Ave. Essex 21nd 3/26/59</u>
PHYSICIAN'S NAME (Type) <u>Eugene C. Bannan</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CC. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connolly</u>		ADDRESS <u>413 Eastern Blvd.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>MAR 31 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2720

CERTIFICATE OF DEATH

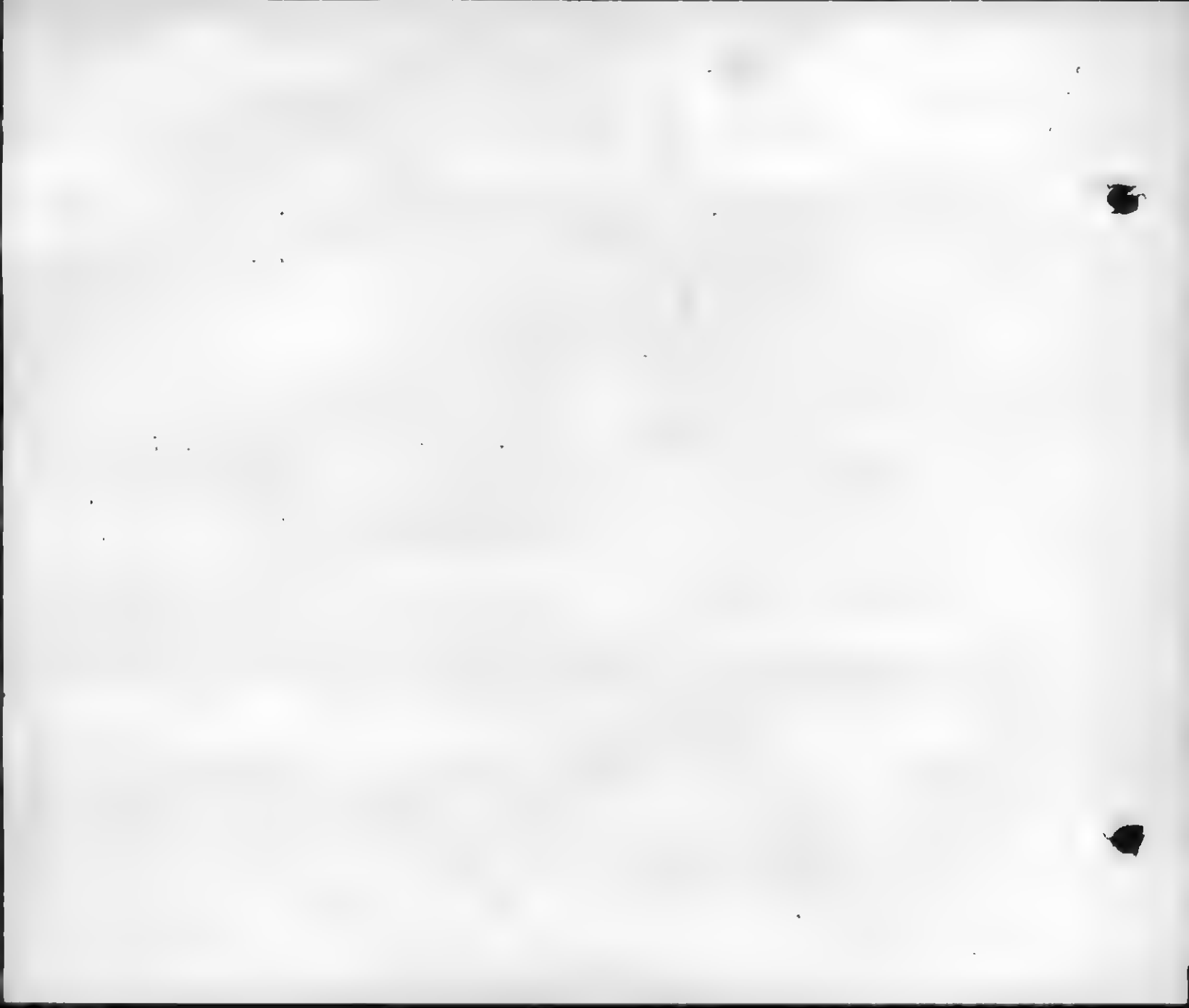
02802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST DENNIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST DENNIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1849 SUTTON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PEARL A KNIGHT First Middle Last		4. DATE OF DEATH MAR. 5, 1959 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1893
9. AGE (In years, birth day) 65 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HARRY SELBY		14. MOTHER'S MAIDEN NAME ANNIE LEARS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN J KNIGHT		Address 76 S MORLEY ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-20 , 1957, to 3-9 , 1959, that I last saw the deceased alive on 12-24 , 1958, and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaefer		DATE SIGNED 3/6/59	
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER		ADDRESS (Street, city or town, state) 401 RANDOM ROAD BALTO. 29 MD.	
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	MAR. 9, 1959	NEW CATHEDRAL	BALTIMORE
23. FUNERAL DIRECTOR'S SIGNATURE HOWARD H HUBBARD		ADDRESS 4107 WILKENS AVE.	
24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02803

Reg. Dist. No.

2820

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b X Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Lane		d. STREET ADDRESS 311 Main Street	
3. NAME OF DECEASED (Type or print) Lydia Elizabeth Knighting		4. DATE OF DEATH March 21, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1879
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Syria, Va.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Robert Southard		14. MOTHER'S MAIDEN NAME Angeline Hurt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Henry Talbert, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 hrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF March 25/59	
22c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02804

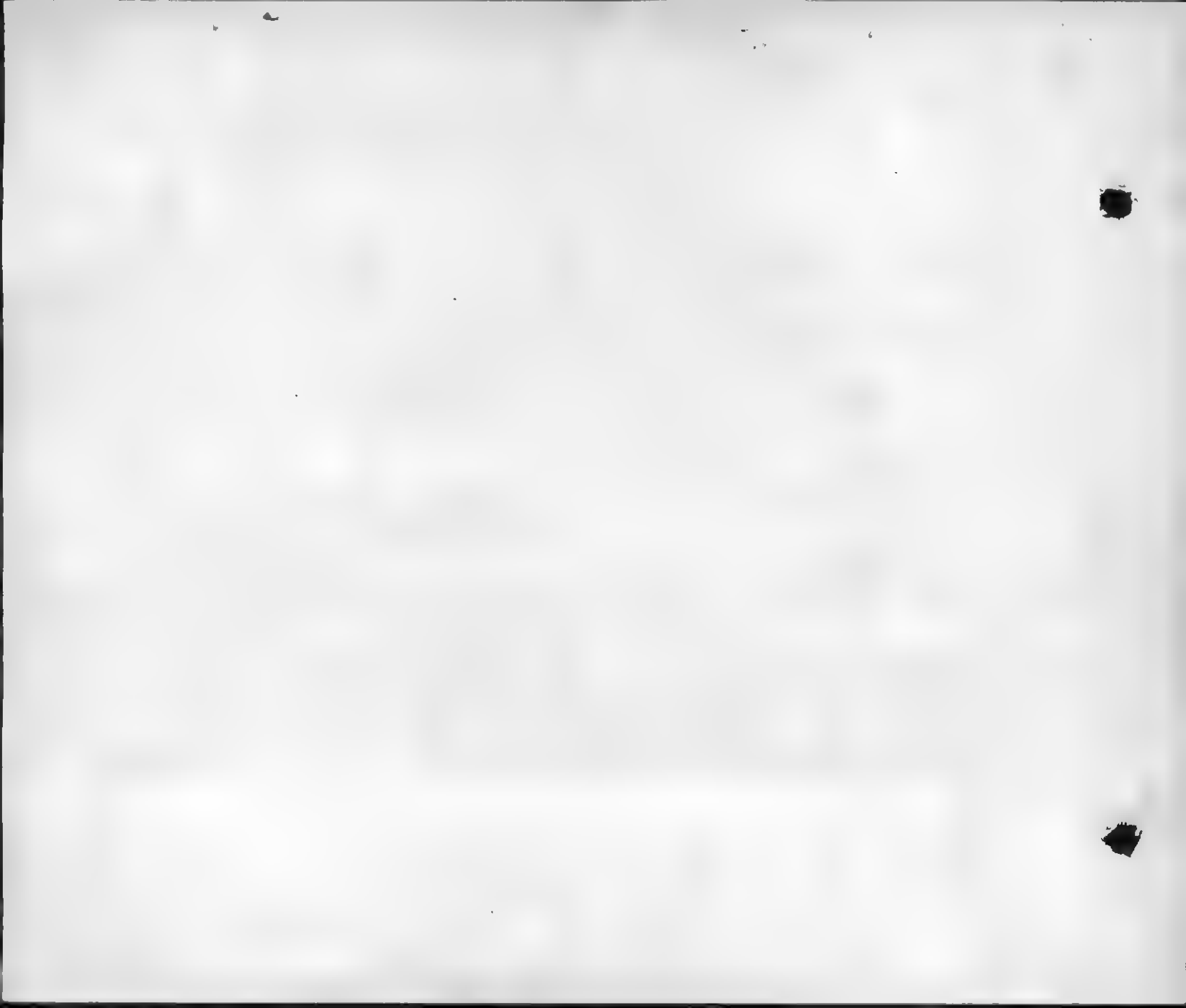
2821

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Inner City, Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3-9-29</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Inner City, Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Residence of deceased</u>			d. STREET ADDRESS <u>1717 Northfield Rd.</u>		e. IS DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>ALBERTA</u> Last <u>KNOPE</u>			4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-31</u>		9. AGE (In years last birthday) <u>27</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Edna and Knoppe</u>			14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Deceased's husband</u> Address <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complication of heart operation</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. _____ DUE TO (c) _____ </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exacerbated by heart condition</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
20c. TIME OF INJURY Month <u>2</u> Day <u>1</u> Year <u>1957</u> Hour <u>6:22</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Baltimore</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-1-57</u>	
EXAMINER'S NAME (Type) <u>E. D. CAPLES, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>	
22d. LOCATION (City, town, or county) <u>WOODLAWN</u>				(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE L. Schwab</u>		ADDRESS <u>Barbara Schwab 210, Parkview Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2822

CERTIFICATE OF DEATH

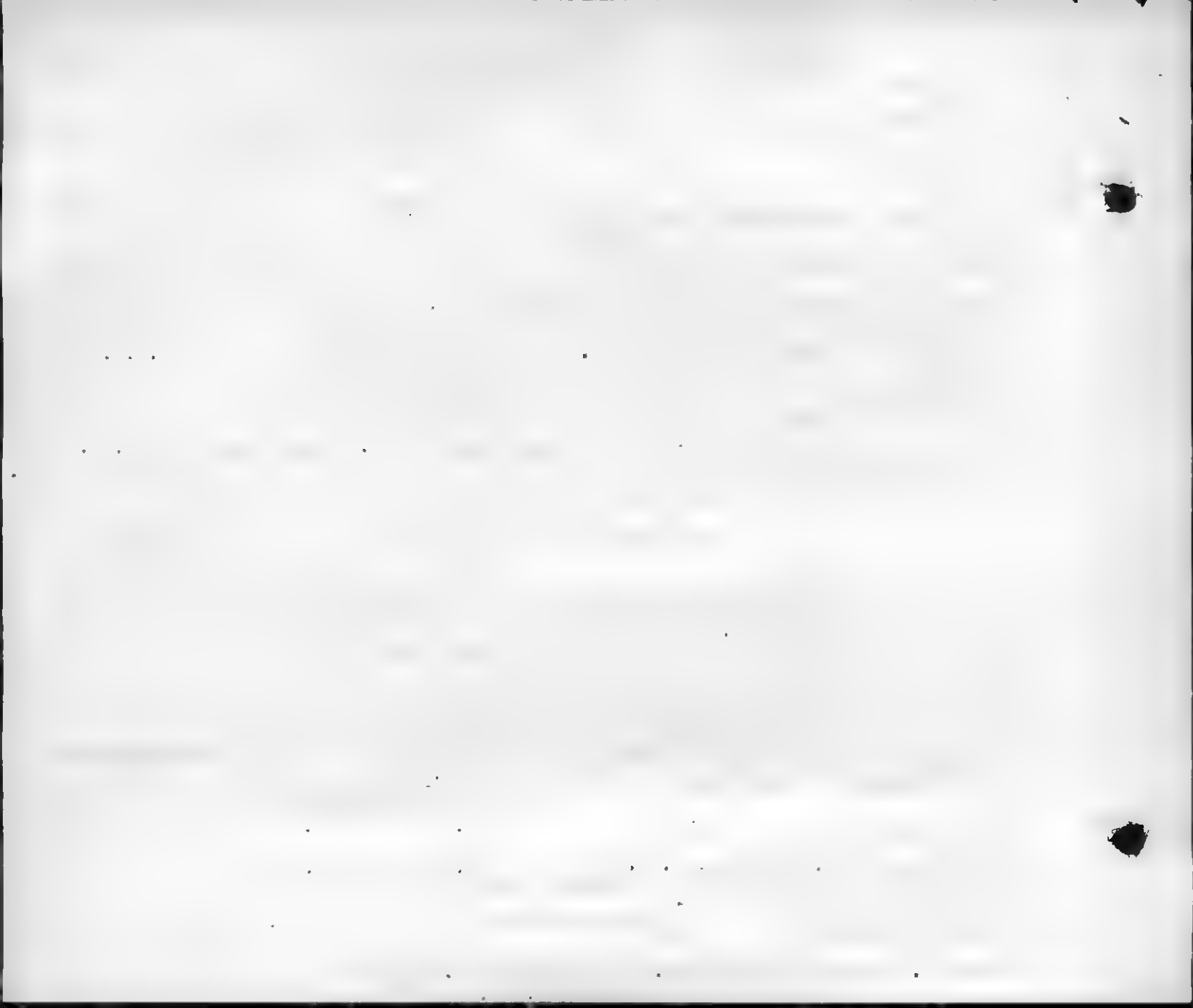
Reg. Dist. No.

02806

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 9 DAYS				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 4304 Leeds Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle AUGUST Last KRIEG				4. DATE OF DEATH Month March Day 20 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 2, 1883	
9. AGE (In years last birthday) 75 yrs		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer				10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Peter Krieg				14. MOTHER'S MAIDEN NAME Louisa Wolman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW I 213-01-9507		17. INFORMANT Clin Records, Vet. Administration Hosp. Ft. Howard			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) ARTERIOSCLEROSIS DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ATRIAL FIBRILLATION. PNEUMONIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from March 11, 1959 to March 20, 1959 and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford				DATE SIGNED 3/20/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M. D.				ADDRESS VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				24a. REC'D BY REGISTRAR MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2721

CERTIFICATE OF DEATH

02807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>4 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1208 GREYSTONE RD.</u>				d. STREET ADDRESS <u>411 ROSE CROFT TERRACE</u>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>M.</u> Last <u>KROHN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>10/30/1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Richard Eirich</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Nicol</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			
16. SOCIAL SECURITY NO. _____				17. INFORMANT <u>1208 GREYSTONE RD. (27)</u> <u>MRS GERARD J. COOGAN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4 DUE TO <u>Hypertensive R.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Seriously</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Seriously</u> (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (After nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____					
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____					
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>Jan 17, 1958</u> to <u>Mar 17, 1959</u> that I last saw the deceased alive on <u>Mar 17, 1959</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Paul B. Byerly</u> M.D.		ADDRESS (Street, city or town, state) <u>3033 W. North Ave</u> DATE SIGNED <u>Apr 16 1959</u>					
PHYSICIAN'S NAME (Type) <u>Paul B. Byerly</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE CEM.</u>			
22d. LOCATION (City, town, or county) <u>BALTO. MARYLAND</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>S. J. ...</u> ADDRESS _____					
24a. REC'D BY REGISTRAR <u>MAR 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>					

3512 Frederick Ave. (27)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2823

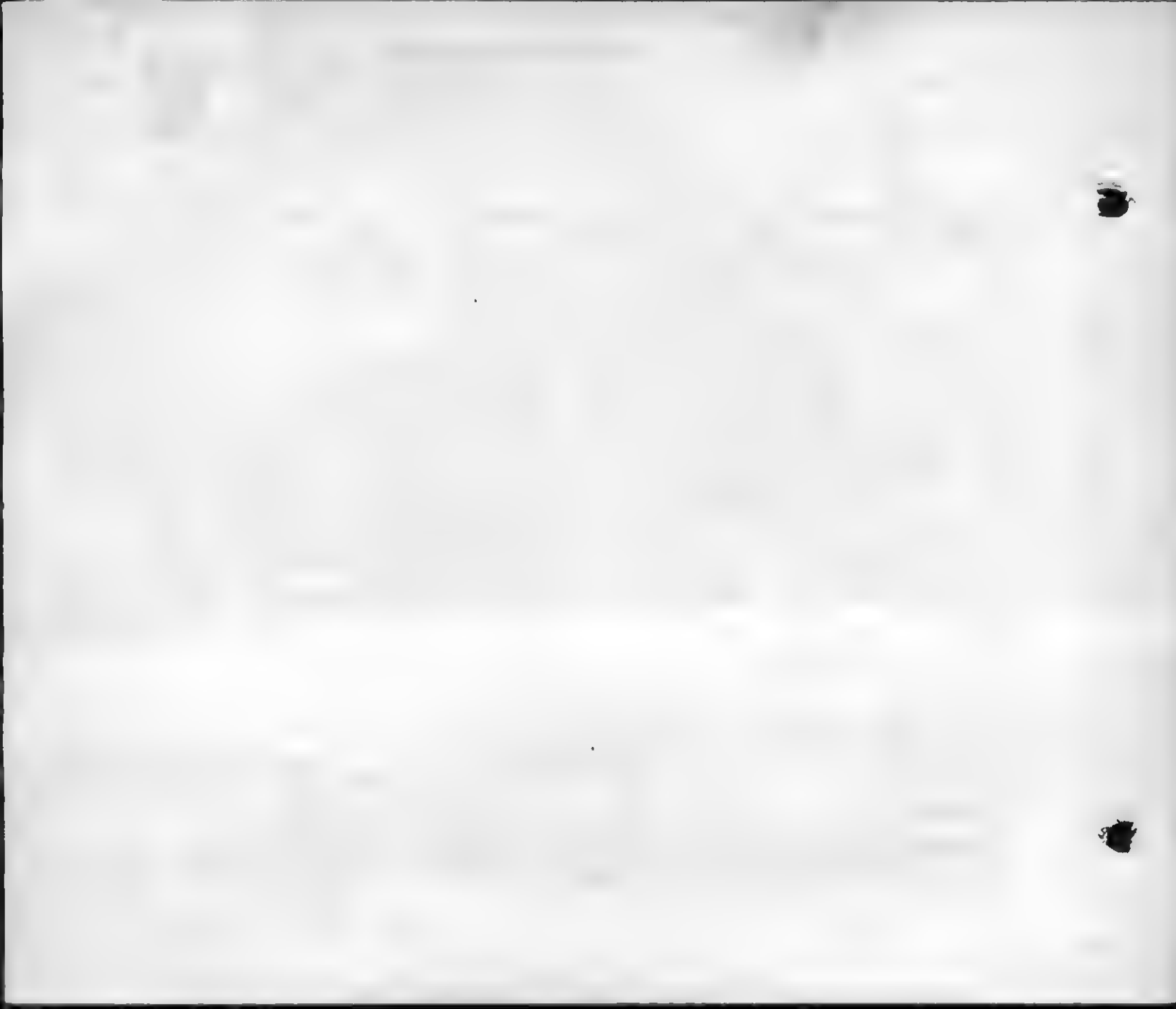
CERTIFICATE OF DEATH

Reg. Dist. No.

02808

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 25yr8mth28dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 1049 West Saratoga Street			
3. NAME OF DECEASED (Type or print) First Morris Middle Last Landy				4. DATE OF DEATH Month 3 Day 1 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailor		10b. KIND OF BUSINESS OR INDUSTRY tailoring		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Joseph Landy				14. MOTHER'S MAIDEN NAME Esther Leihman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE							
DUE TO (b) ARTERIOSCLEROSIS GENERALIZED, SEVERE							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 27, 1958 , to March 1, 1959 , that I last saw the deceased alive on March 1, 1959 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3/1/1959			
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-2-59		22c. NAME OF CEMETERY OR CREMATORY Rosedale		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Jr ADDRESS 2100 Canton Pl				24a. REC'D BY REGISTRAR DATE MAR 3 59		24b. REGISTRAR'S SIGNATURE Wm L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02809

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 66 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 6032 CARTER AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EFFIN L. LEHUKEY				4. DATE OF DEATH Month Day Year MARCH 23 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 16, 1892	
9. AGE (In years last birthday) 66 yrs		10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN				10b. KIND OF BUSINESS OR INDUSTRY CROWN CORK & SEAL		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME LOUIS LEHUKEY				14. MOTHER'S MAIDEN NAME MARY CHORPALIK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO 220-22-1403		17. INFORMANT Address CLIN. REC. VET. ADM. HOSP. FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LIVER 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from January 16, 19 59 , to March 23, 19 59 , and that death occurred at 12:55 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED VAH, Fort Howard, Maryland 3/23/59 ACTUAL SIGNATURE John W. Crawford M.D. VAH, Fort Howard, Maryland 3/23/59 PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M. D. VAH, Fort Howard, Maryland 3/23/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Buck Funeral Home, 5305 Harford Road				24a. REC'D BY REGISTRAR MAR 26 '59			
ADDRESS Baltimore, Md.				24b. REGISTRAR'S SIGNATURE Arthur E. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar upon burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02810

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b Rural (Dundalk) Baltimore			
3. NAME OF DECEASED (Type or print) Thomas Lewandowski				d. STREET ADDRESS 6833 Holabird Ave.			
4. DATE OF DEATH Month March Day 28 Year 59				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1897	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-4376		17. INFORMANT Laura Lewandowski Address 6833 Holabird Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/59		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc				ADDRESS 401 S. Chester		24a. REC'D BY REGISTRAR MAR 31 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2826

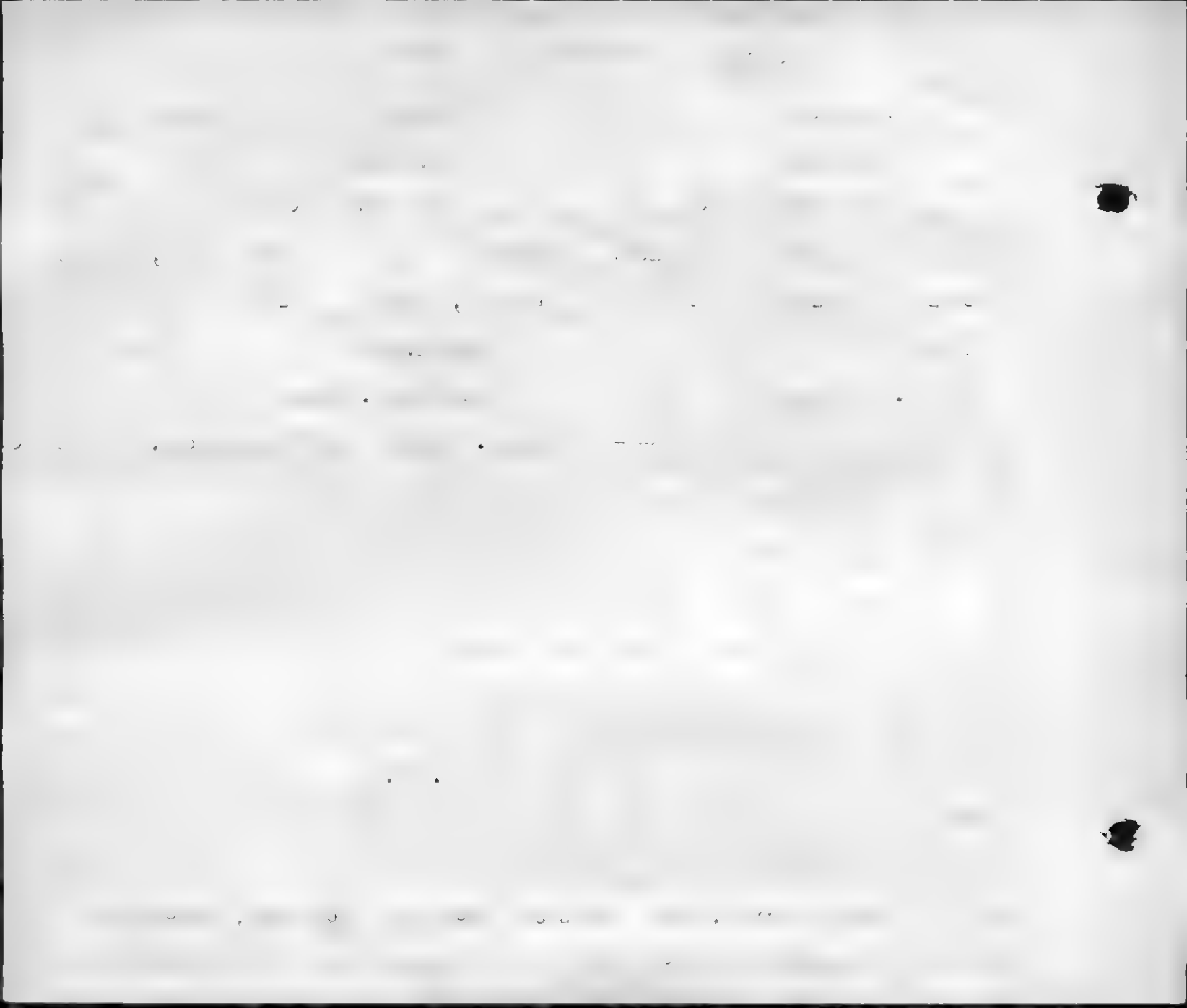
CERTIFICATE OF DEATH

Reg. Dist. No.

02811

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4220 Darnell Road				d. STREET ADDRESS 4220 Darnell Road			
3. NAME OF DECEASED (Type or print) First Minnie Middle Elsie Last Lewis				4. DATE OF DEATH Month March Day 7 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1886		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank W. Hoffman				14. MOTHER'S MAIDEN NAME Elizabeth C. Yocum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Frank M. Dunkes Address 4220 Darnell Road, Baltimore 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular-renal disease DUE TO (c) Arteriosclerosis Generalized							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia - right							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from November, 1958 , to March 7, 1959 , that I last saw the deceased alive on March 6, 1958 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel B. Wolfe				ADDRESS (Street, city or town, state) 13312 Poth Ave Baltimore 13, Md.			
PHYSICIAN'S NAME (Type) SAMUEL B. WOLFE				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF March 9, 1959		22c. NAME OF CEMETERY OR CREMATORY Pottstown (West end) Pottstown, Pennsylvania		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Address 3631 Falls Road				24a. REC'D BY REGISTRAR March 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

Notary P. Burgee Baltimore 11



2707

CERTIFICATE OF DEATH

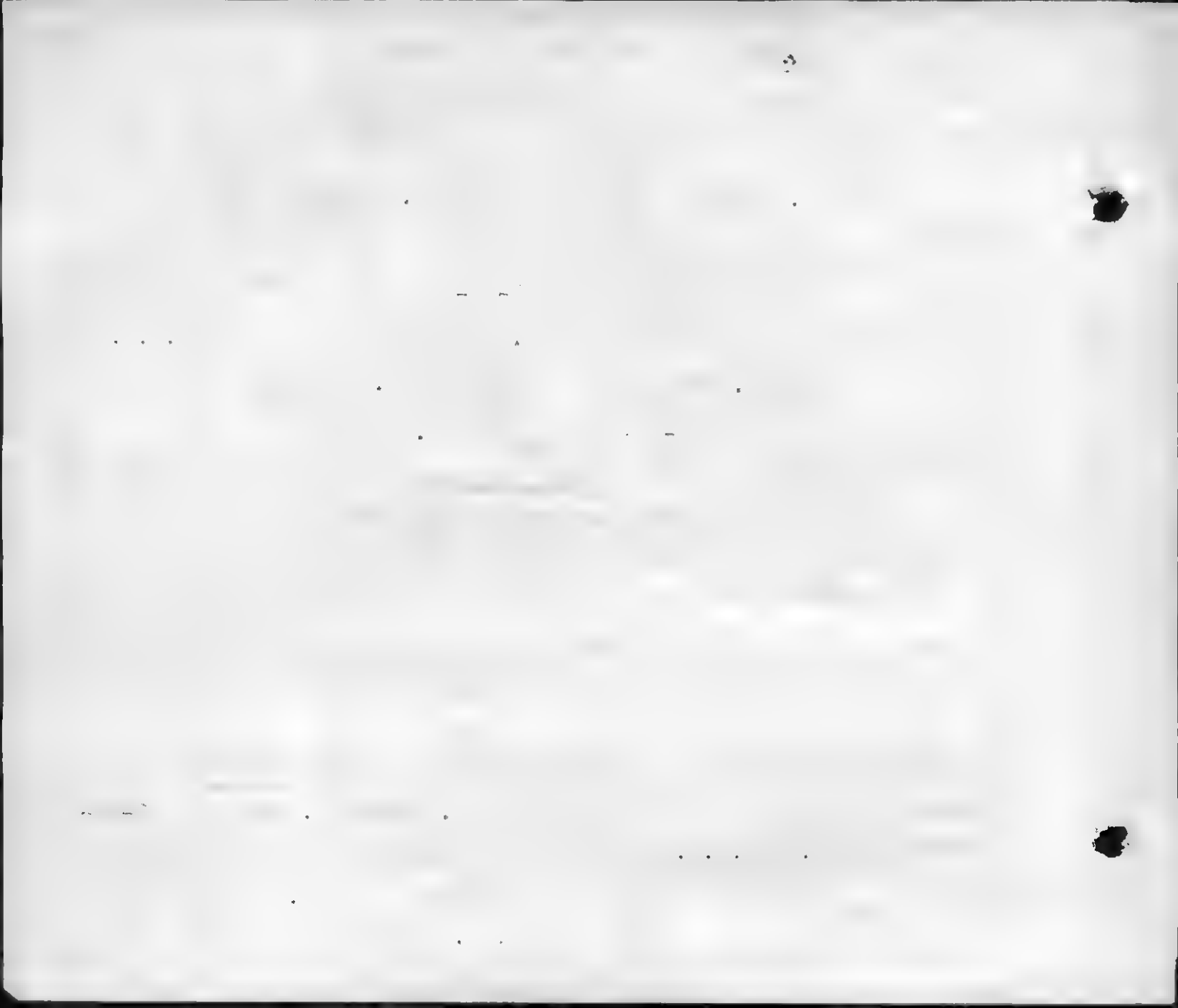
Reg. Dist. No.

02812

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2802 W. Woodwell Road		e. STREET ADDRESS 2802 W. Woodwell Road	
3. NAME OF DECEASED (Type or print) First ESTELLA Middle MHHALA Last LIDDLE		4. DATE OF DEATH Month March Day 16 Year 1959	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-26-1914
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Drapery Indust.	
11 BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Lineberry		14. MOTHER'S MAIDEN NAME Hannah E. Robinson	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] no		16 SOCIAL SECURITY NO 231-16-2767	
17 INFORMANT Joseph A. Liddle		Address (Same)	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanosarcoma 170.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary on skin of back with DUE TO (c) Generalized Metastases			INTERVAL BETWEEN ONSET AND DEATH 16 Mos
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 1957 , to Mar. 1959 , that I last saw the deceased alive on March 16, 1959 , and that death occurred at M , from the causes and on the date stated above ADDRESS (Street, city or town, state) 11 E. Chase St. Balt (2) DATE SIGNED 3-16-59			
ACTUAL SIGNATURE Karl F. Mech, M.D.		PHYSICIAN'S NAME (Type) Karl F. Mech, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/20/59	22c. NAME OF CEMETERY OR CREMATORY Gladeville Methodist	22d. LOCATION (City, town, or county) (State) Galax, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley		24a. REC'D BY REGISTRAR MAR 19 59	24b. REGISTRAR'S SIGNATURE Arthur S. Finner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

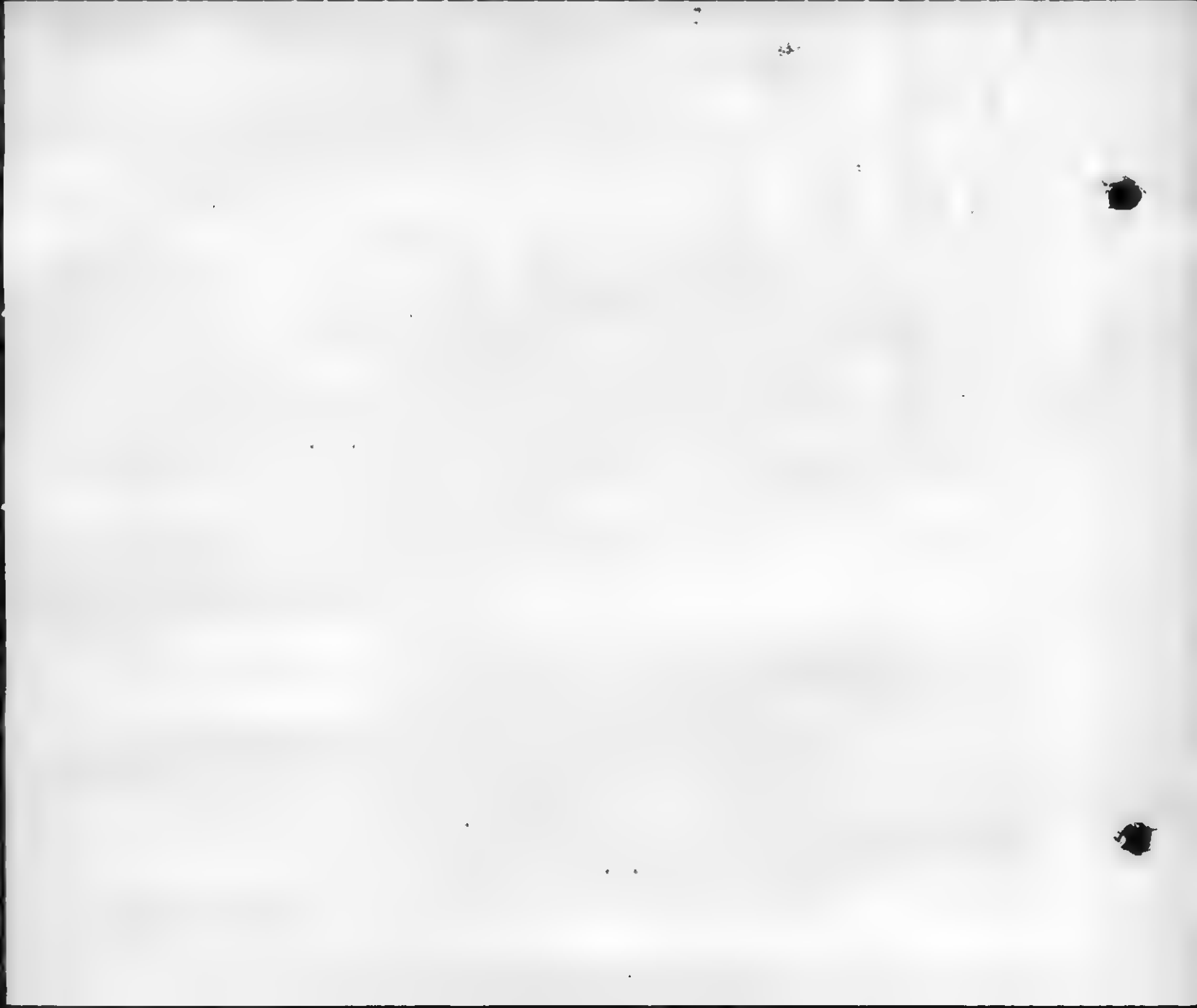


2827
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN b 5 MONTHS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEDERALS BURG d. STREET ADDRESS 312 CHARLES ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE LIMORE		4. DATE OF DEATH Month Day Year 3 26 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1879
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY DELAWARE	
11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN LIMORE		14. MOTHER'S MAIDEN NAME MARGARET THOMAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 217-14-8892	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL THROMBOSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/17 , 19 58 , to 3/26 , 19 59 , that I last saw the deceased alive on 3/26 , 19 59 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____			
ACTUAL SIGNATURE W. Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Son, Federalsburg Md		24a. REC'D BY REGISTRAR DATE MAR 31 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician, and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 1 10-24-59 et 2722 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02814

Reg. Dist. No.

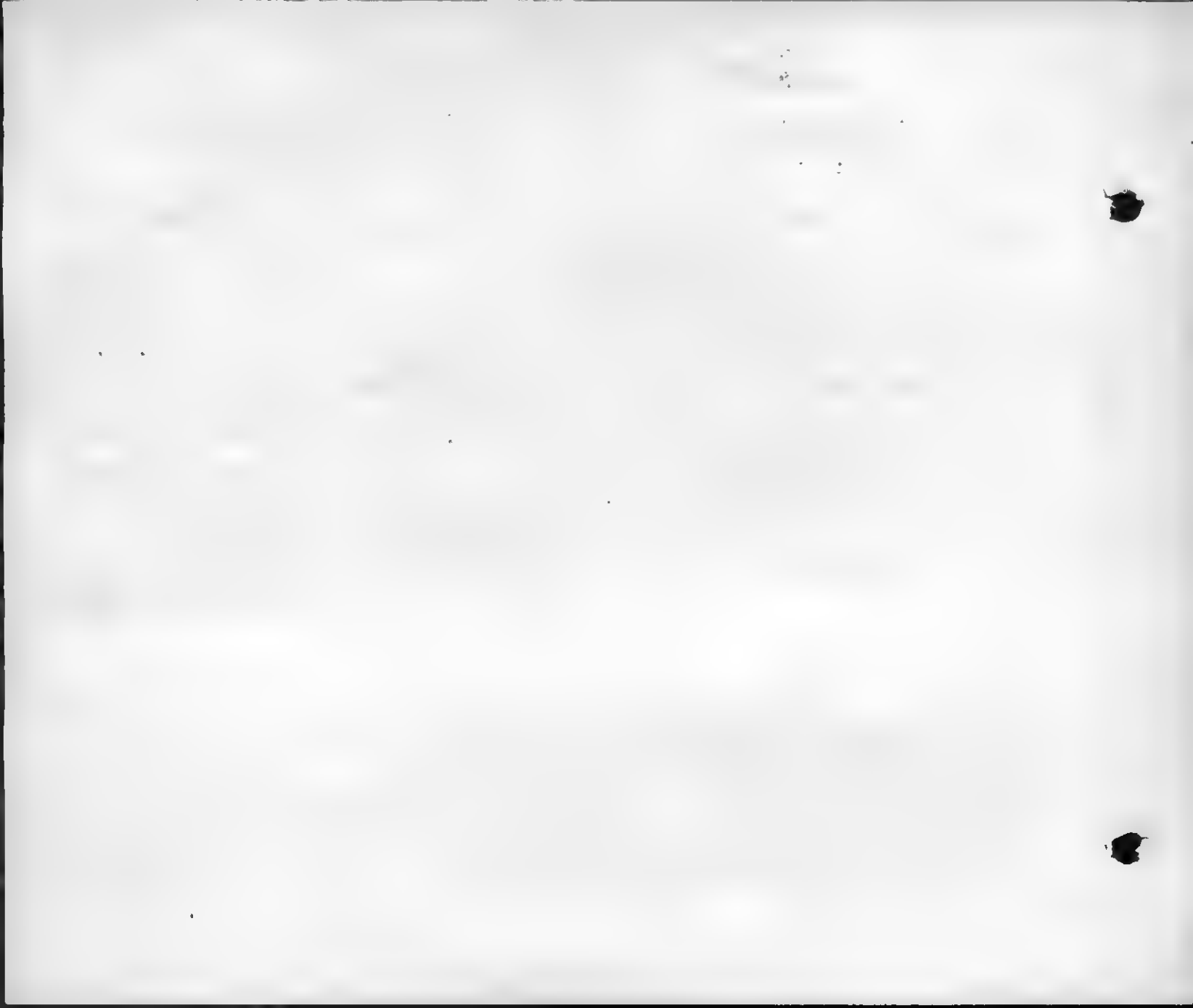
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1204 Maiden Choice Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Ella Lotz		4. DATE OF DEATH Month Day Year March 16, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1871
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR IF UNDER 74 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Winks		14. MOTHER'S MAIDEN NAME Marian Cleary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Clara E. Lotz 1204 Maiden Choice Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Artery Disease DUE TO (c) Coronary Artery Disease INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-14 19 50 , to 3-16 19 59 , that I last saw the deceased alive on 3-14 19 59 , and that death occurred at 10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Unruh Jr M.D. 1227 W. Union Blvd		DATE SIGNED	
PHYSICIAN'S NAME (Type) John			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/19/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23 FUNERAL DIRECTOR'S SIGNATURE John P. Unruh Jr		24a. RECEIVED BY REGISTRAR 1959	24b. REGISTRAR'S SIGNATURE W. L. Harris

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Unruh, 1227 W. Union Blvd, Washington 1300



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2828

Reg. Dist. No. 02815

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admittance) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Essex (21)</u>		c LENGTH OF STAY IN 1b <u>50</u> <u>Essex (21)</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 213 "B" Golupski Rd.</u>		d STREET ADDRESS <u>Box 213 "B" Golupski Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Henry Joseph Luhrman</u>		4 DATE OF DEATH <u>March 6,</u> <u>1959</u>	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 9, 1896</u>
9 AGE (In years last birthday) <u>59</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Luhrman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Jelss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16 SOCIAL SECURITY NO <u>217-03-1375</u>	
17. INFORMANT <u>David Luhrman</u>		Address <u>Box 213</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXTENSIVE CANCER OF BOTH</u> DUE TO (b) <u>Lungs - Prob. H. Lox in origin</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>?</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> or while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Essex, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bruzdzinski</u> ADDRESS <u>100 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 11 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/interment permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2708

02816

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02817

2709

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TURNERS STATION</u>		c. LENGTH OF STAY IN 1b <u>10 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TURNERS STATION</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>727 N. AVONDALE RD</u>				d. STREET ADDRESS <u>727 N. AVONDALE RD</u>			
3. NAME OF DECEASED (Type or print) <u>F. LLANORA</u> First <u>LYNCH</u> Middle Last				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STEVEN CAINE</u>				14. MOTHER'S MAIDEN NAME <u>LOTTIE SPENCER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>LOTTIE JOHNSON</u> Address <u>727 N. AVONDALE RD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO (b) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MAAUBURN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marjorie P. Hays</u> ADDRESS <u>638 N. Gilman St</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02818

2829

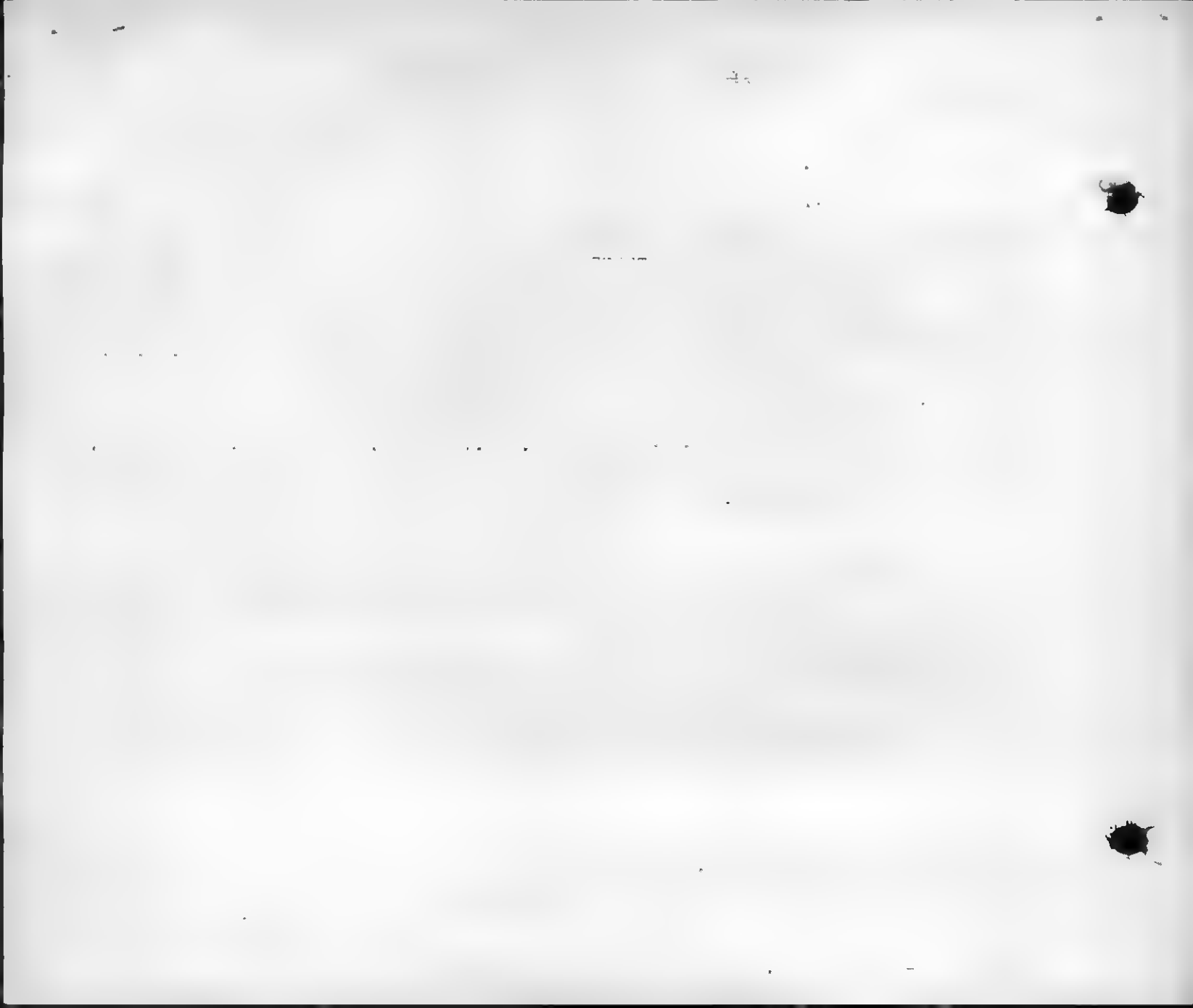
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 46 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS Beaver Dam Swimming Club			
3. NAME OF DECEASED (Type or print) First McDOWELL Middle LYON Last LYON				4. DATE OF DEATH Month March Day 3 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 14, 1895		9 AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY Painter ans Writer		11 BIRTHPLACE (State or foreign country) Bristol, Tennessee		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME James P. Lyon				14. MOTHER'S MAIDEN NAME Elizabeth McDowell			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW I		16 SOCIAL SECURITY NO 212-12-2378		17. INFORMANT Address Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASCITES AND HYDROTHORAX, BILATERAL						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from January 16, 19 59 , to March 3, 19 59 , and that death occurred at 2:10 AM , from the causes and on the date stated above. DATE SIGNED 3/3/59 ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND							
ACTUAL SIGNATURE Chien Wei Lan		DATE SIGNED 3/3/59					
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		ADDRESS 6009 Harford Road Baltimore 14, Maryland		24a REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2830

CERTIFICATE OF DEATH

02819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARY				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (20)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (20)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Ave. Chase, Md.				d. STREET ADDRESS Eastern Ave. Chase, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Maddox				4. DATE OF DEATH Month March Day 30 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1873		9. AGE (In years last birthday) yrs 85	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Maddox				14. MOTHER'S MAIDEN NAME Frances Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-1038		17. INFORMANT Margaret Ann Maddox		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma DUE TO (c) leucoglobus							INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/29, 1959 to 3/30, 1959 , that I last saw the deceased alive on 3/29, 1959 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Platt				ADDRESS (Street, city or town, state) 424 Eastern Ave.		DATE SIGNED 3/31/59	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.				M.D. Essex, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-59		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdzinaki				ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR DATE APR 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

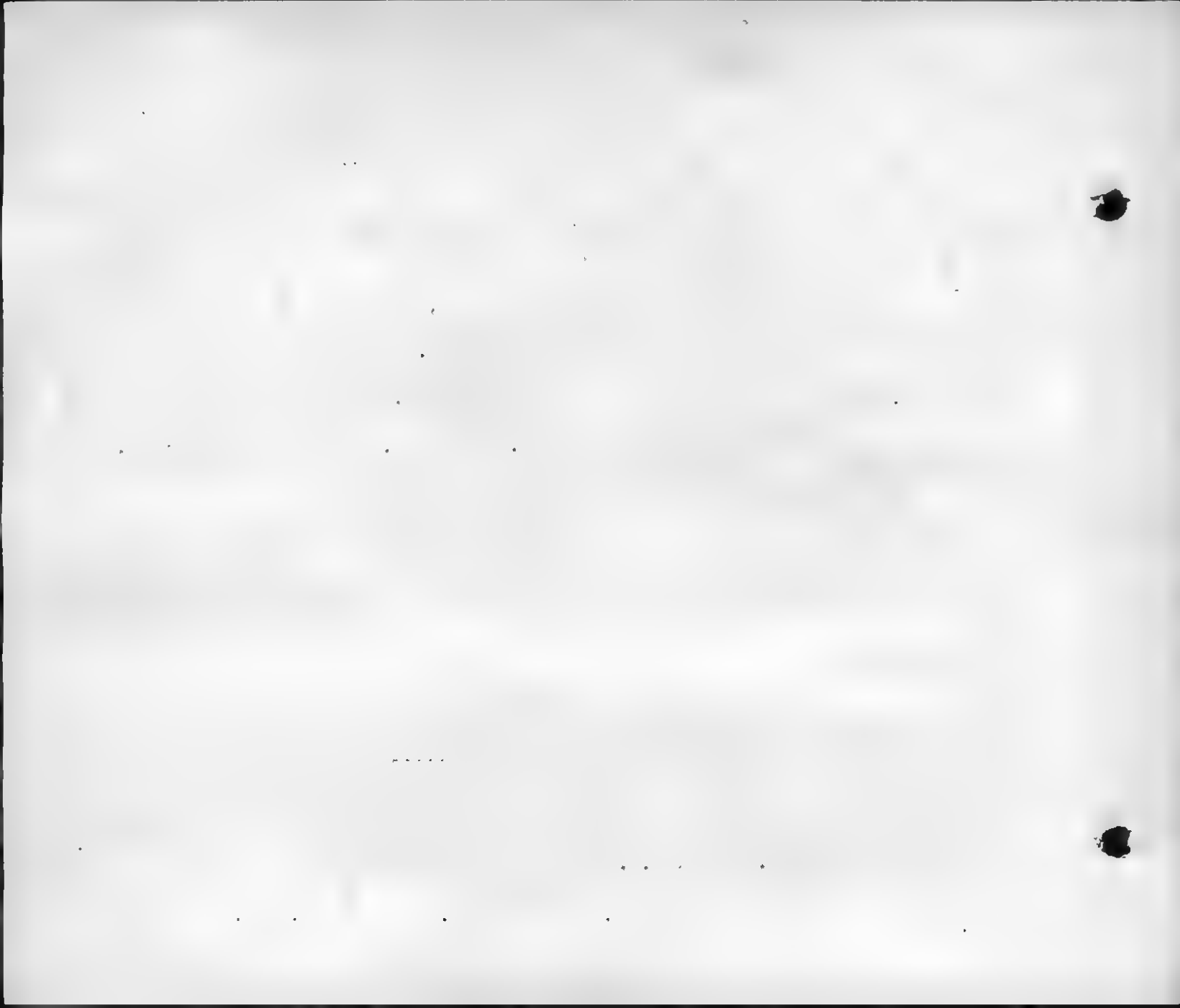
02820

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
c. LENGTH OF STAY IN TB		d. STREET ADDRESS 3518 Rhom Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3518 Rhom Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle (Frances) Last F. MALONE		4. DATE OF DEATH Month March Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1948
9. AGE (In years last day) 10 yrs		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Everitt L. Malone		14. MOTHER'S MAIDEN NAME Frances A. Beyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Everitt L. Malone		Address 3518 Rhom Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheobronchitis 500 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED March 6, 1959	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/59	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Dickner & Sons - Balto.		24a. REC'D BY REGISTRAR MAR 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2832

CERTIFICATE OF DEATH

Reg. Dist. No.

02821

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCHearn</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG Home</u>		d. STREET ADDRESS <u>3007 Pelham Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Hanna J. Marchant</u>		4. DATE OF DEATH <u>March 14</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>John Gantz</u>		14. MOTHER'S MAIDEN NAME <u>Regina M. Schlgleich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records Avc. Home</u>		Address <u>Campfield rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) - Cerebral Hemorrhage</u> DUE TO <u>(2) - Arterio Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arterio Respiratory Infection</u> (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>54 hrs.</u> <u>5 yrs.</u> <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June - 16 - 1955</u> to <u>March 13 - 1959</u> , that I last saw the deceased alive on <u>March - 12 - 1959</u> , and that death occurred at <u>8:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		M.D. <u>4108 Liberty Hts - Balto - 7-M.</u> DATE SIGNED <u>3-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers -</u>		<u>4108 Liberty Hts - Balto - 7-M.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Violetville</u>		22d. LOCATION (City, town or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Deenmann</u>		ADDRESS <u>6067 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Cl. J. G. H. H.</u>	
DATE <u>MAR 18 59</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02822

2833

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3026 Tennessee Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 3026 Tennessee Avenue e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle J. Last MARKELL		4. DATE OF DEATH Month March Day 15 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1909 9. AGE (In years last birthday) 49 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wythville, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Arron Bell		14. MOTHER'S MAIDEN NAME Elizabeth Church	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-5597	
17. INFORMANT Owen L. Markell		Address 3026 Tennessee Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal cirrhosis 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i> EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 16, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard H. Hubbard</i> ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE MAR 19 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you. File pages 1 and 2 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2834

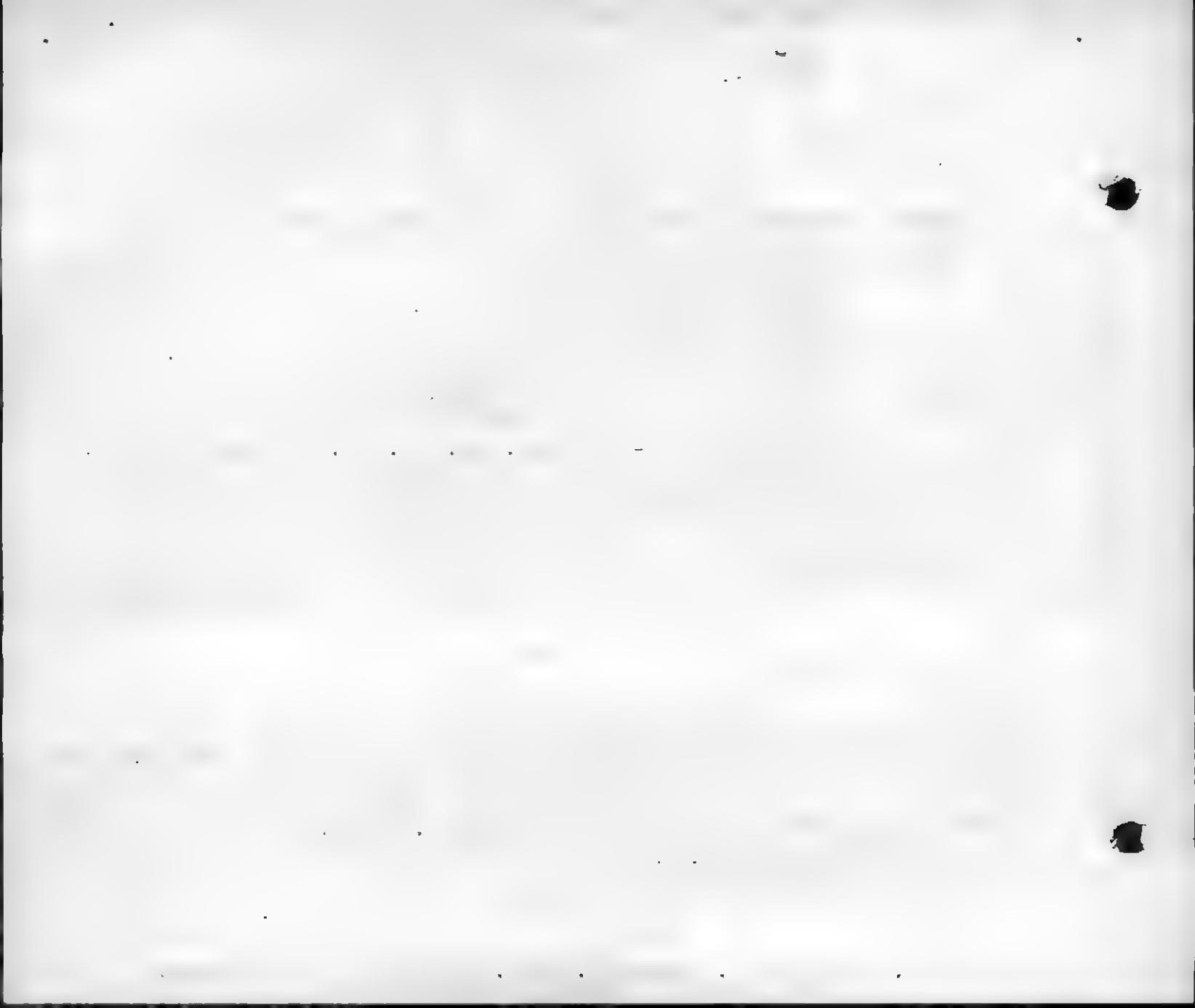
CERTIFICATE OF DEATH

Reg. Dist. No.

02823

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 1607 Pennsylvania Ave	
3. NAME OF DECEASED (Type or print) First HENRY Middle G Last MASSEY		4. DATE OF DEATH Month March Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1901
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Food Fair Store	
11. BIRTHPLACE (State or foreign country) Rock Hill, South Carolina		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME Lot Massey		14. MOTHER'S MAIDEN NAME Matilda Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-10-7643	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO LUETIC AORTIC INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 2, 19 59 to March 26, 19 59 , and that death occurred at 2:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Ft. Howard, Md 3/26/59			
ACTUAL SIGNATURE Donald D Mark		M.D. VAH Ft. Howard, Md	
NAME (Type) DONALD D MARK, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George G. Nelson		ADDRESS 1348 N. Calhoun St. Balto. Md	
24a. REC'D BY REGISTRAR MAR 20 59		24b. REGISTRAR'S SIGNATURE Arthur J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

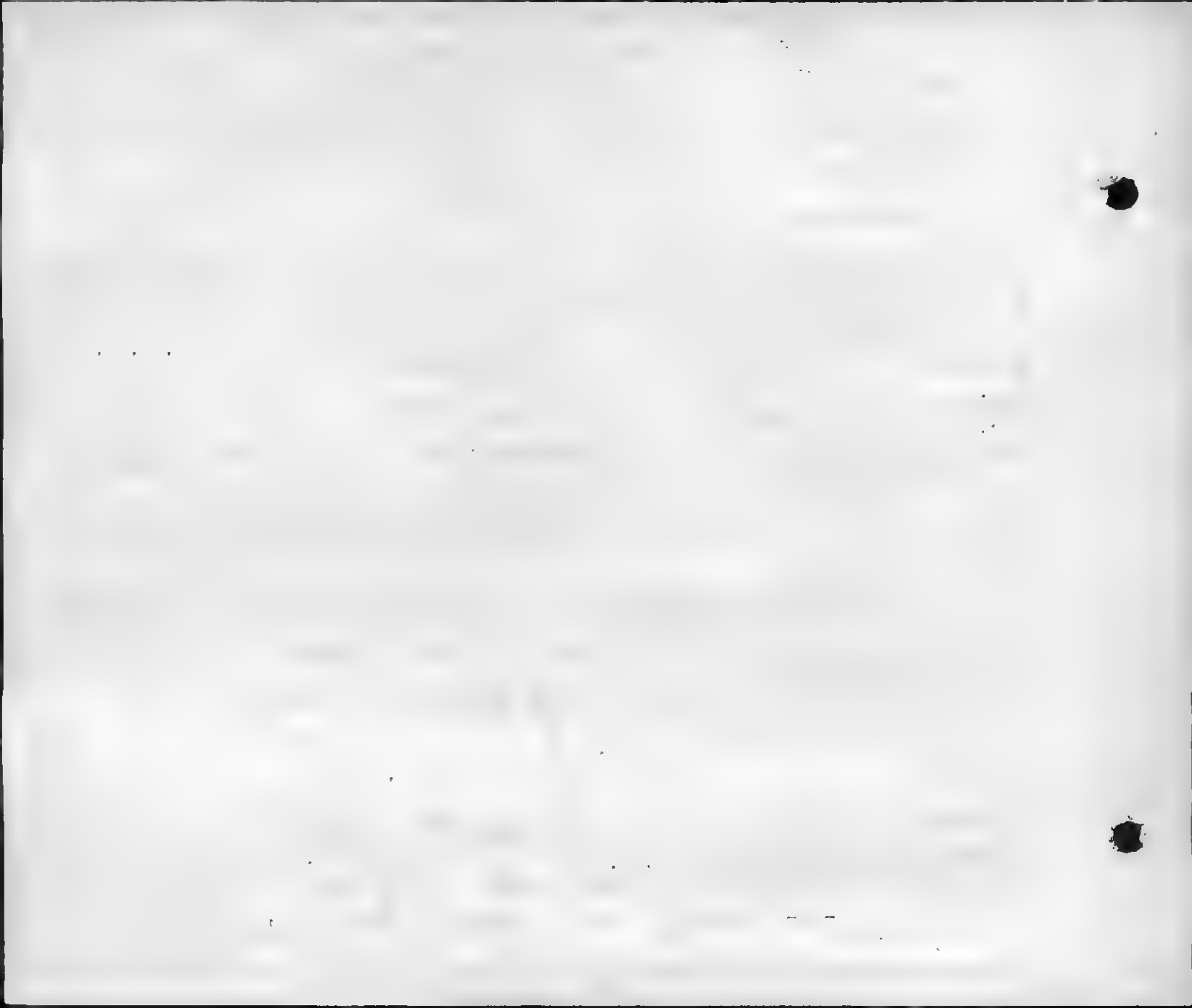


1
2835 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

02824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>1yr8mth18dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>Route #5 - Lakeshore Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Etta</u> Last <u>Maxwell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1887</u>
9. AGE (In years lost, birthday) yrs <u>71</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>defense work</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lewis Rosell</u>		14. MOTHER'S MAIDEN NAME <u>Susan Elizabeth Grant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis, severe</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 16</u> , 19 <u>58</u> , to <u>March 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 19</u> , 19 <u>59</u> , and that death occurred at <u>3:05p.m.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Stella Wachsker</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 3-19-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsker, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>3-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Tuckerton, New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook, Inc 1217 St Paul St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2836

CERTIFICATE OF DEATH

02825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RASPBURG 6</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RASPBURG 6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 383 Old Philadelphia Rd</u>		d. STREET ADDRESS <u>Box 383 X Rd Old Philadelphia Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN W. MCALLISTER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 24 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-1890</u>
9. AGE (In years last birthday) <u>58 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE CONSTR</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES MCALLISTER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 32 0402</u>	
17. INFORMANT <u>EDNA SMITH</u>		Address <u>Box 383 Old Phila. Rd 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Atherosclerosis, generalized</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, bilateral</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>16 May, 1958</u> to <u>24 May, 1959</u> , that I last saw the deceased alive on <u>23 May, 1959</u> , and that death occurred at <u>4:21 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Howard Goodman</u>		M.D. <u>604 Harkness Rd Baltimore MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDAN PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank George Elton</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
ADDRESS <u>900 N. E. Street, Apt. 5</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knap</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02826

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines, Fusting Ave</u>				d. STREET ADDRESS <u>1241 Voight Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>McFadden</u> Last <u></u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 11, 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Michael</u>				14. MOTHER'S MAIDEN NAME <u>Neher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Leticia Mae Fadden</u> Address <u>1241 Voight Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO (b) <u>Cardio vascular disease .Senility,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Malnutrition Dehydration</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Feb. 21, 1959</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Perry</u>				ADDRESS <u>5646 Carville Ave.</u>		24a. REC'D BY REGISTRAR <u>MAR 31 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2838

CERTIFICATE OF DEATH

Reg. Dist. No.

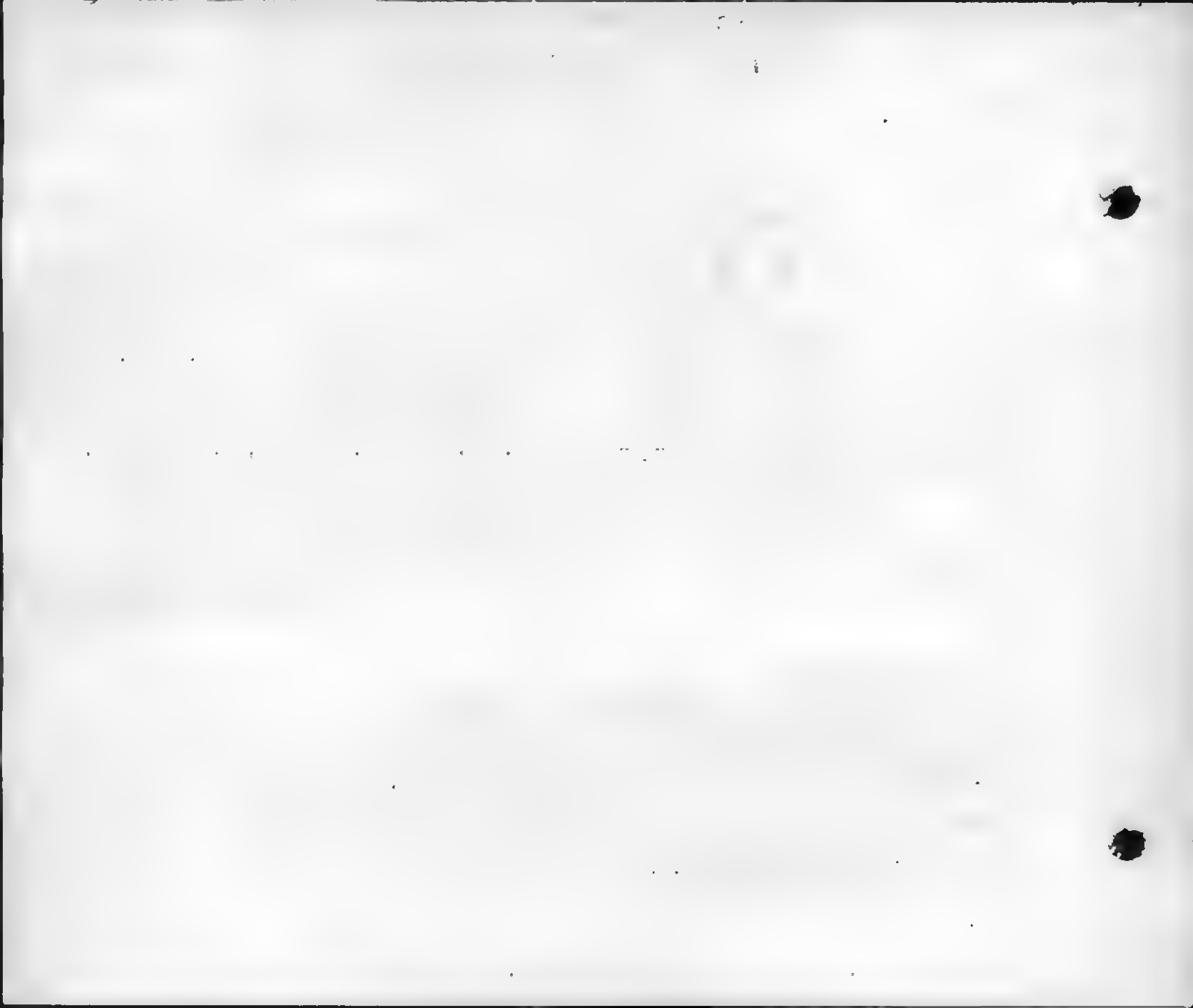
02827

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm'ss on) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 168 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 750 West North Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT C. McMILLAN		4. DATE OF DEATH Month Day Year March 9 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1908	9. AGE (In years last birthday) 50 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper - Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Matthew McMillan			14. MOTHER'S MAIDEN NAME Minnie Zimmerman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-05-7991		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 162.1 BRONCHOGENIC CARCINOMA, LEFT UPPER LOBE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 22, 1958, to March 9, 1959, that the deceased died on March 9, 1959, at 6:00 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Crawford, M.D.		ADDRESS (Street, city or town, state) FORT HOWARD, MARYLAND					
NAME (Type) JOHN W. CRAWFORD, M.D.		DATE SIGNED 3/10/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Jm. Cook-Blight, Inc.		ADDRESS 6009 Harford Rd. Baltimore 14, Md.		24a. REC'D BY REGISTRAR MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kane	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



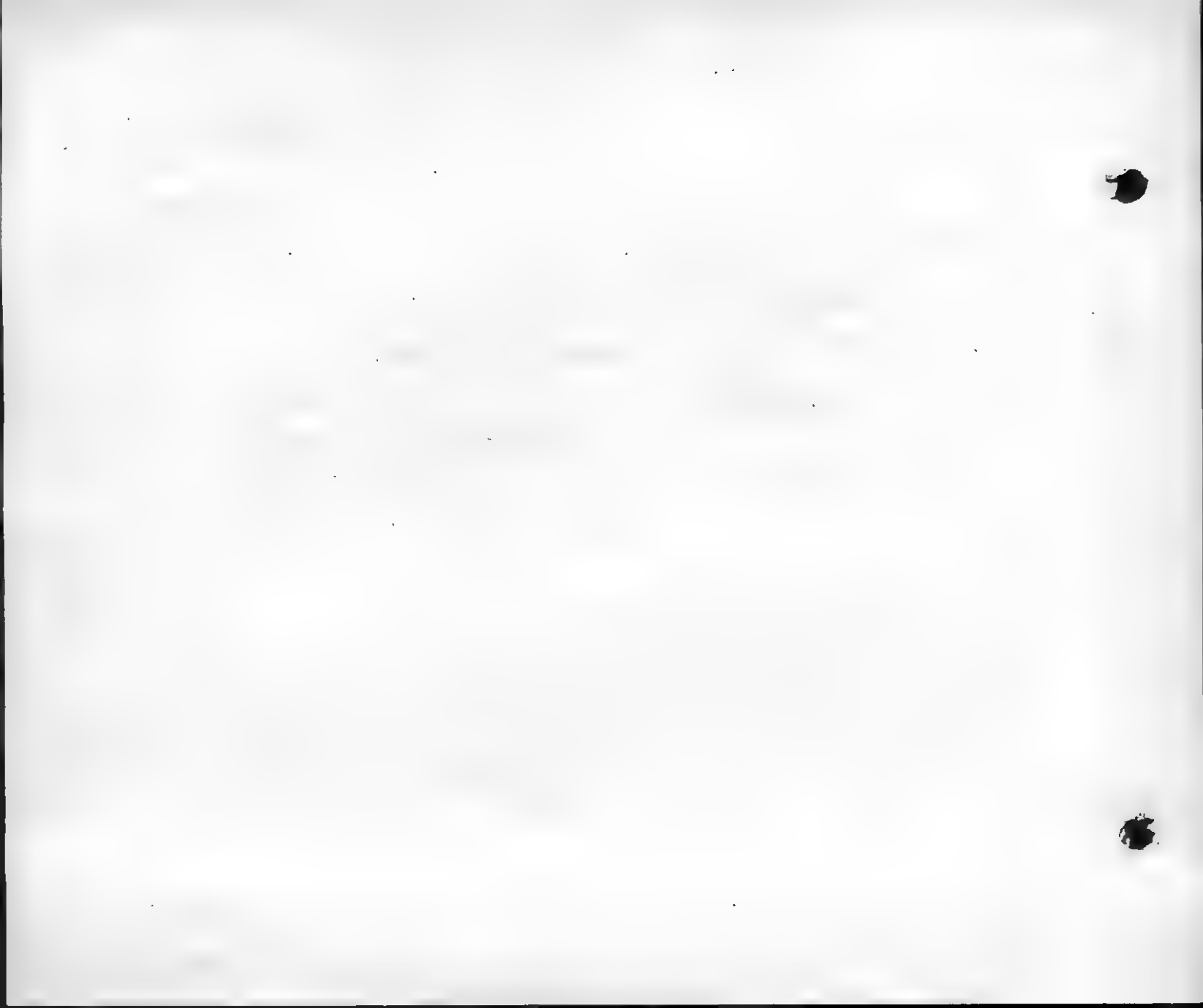
2839

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb <u>7</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>15606 Queen Anne</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Grace Meehan</u> First Middle Last		4. DATE OF DEATH <u>March 7 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/1877</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Wm. Lunsinger</u>	
14. MOTHER'S MAIDEN NAME <u>J. Lyon</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>Joseph Meehan</u>	
16. SOCIAL SECURITY NO. <u>442x</u>		17. INFORMANT <u>Joseph Meehan</u> Address <u>2 days 7 years?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Cardiac Arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) <u>Cardio-Vascular-Renal disease</u> DUE TO (c) <u>7 years?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 6 1957</u> to <u>Mar 7 1959</u> that I last saw the deceased alive on <u>Mar 7 1959</u> and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Urban</u> M.D.		ADDRESS (Street, city or town, state) <u>805 S. Frederick Ave 38th</u> DATE SIGNED <u>3.7.59</u>	
PHYSICIAN'S NAME (Type) <u>George E. URBAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Mott + Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon between pages 1 and 2, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1898-1900 11.26243 3-26-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02829

2840

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8213 Old Harford Road</u>				d. STREET ADDRESS <u>8213 Old Harford Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Joseph Herman Metzger, Sr.</u>				4. DATE OF DEATH Month Day Year <u>March 18th 19 59</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, (1890)</u>		9. AGE (In years last birthday) <u>68</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Baker</u>				10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph Metzger</u>				14. MOTHER'S MAIDEN NAME <u>?</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-07-3372</u>		17. INFORMANT Address <u>Mrs. Eleanor Agnes Metzger, same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>10 7 5 min</u> <u>10 7 45</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 19 57</u> to <u>Present</u> 19 , that I last saw the deceased alive on <u>April 12 59</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Road #14 Baltimore, Maryland</u>				DATE SIGNED <u>3/18/59</u>			
PHYSICIAN'S NAME (Type) <u>Frank T. Kasik, Jr.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>3/21/59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>						24a. REC'D BY REGISTRAR <u>MAR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2841

CERTIFICATE OF DEATH

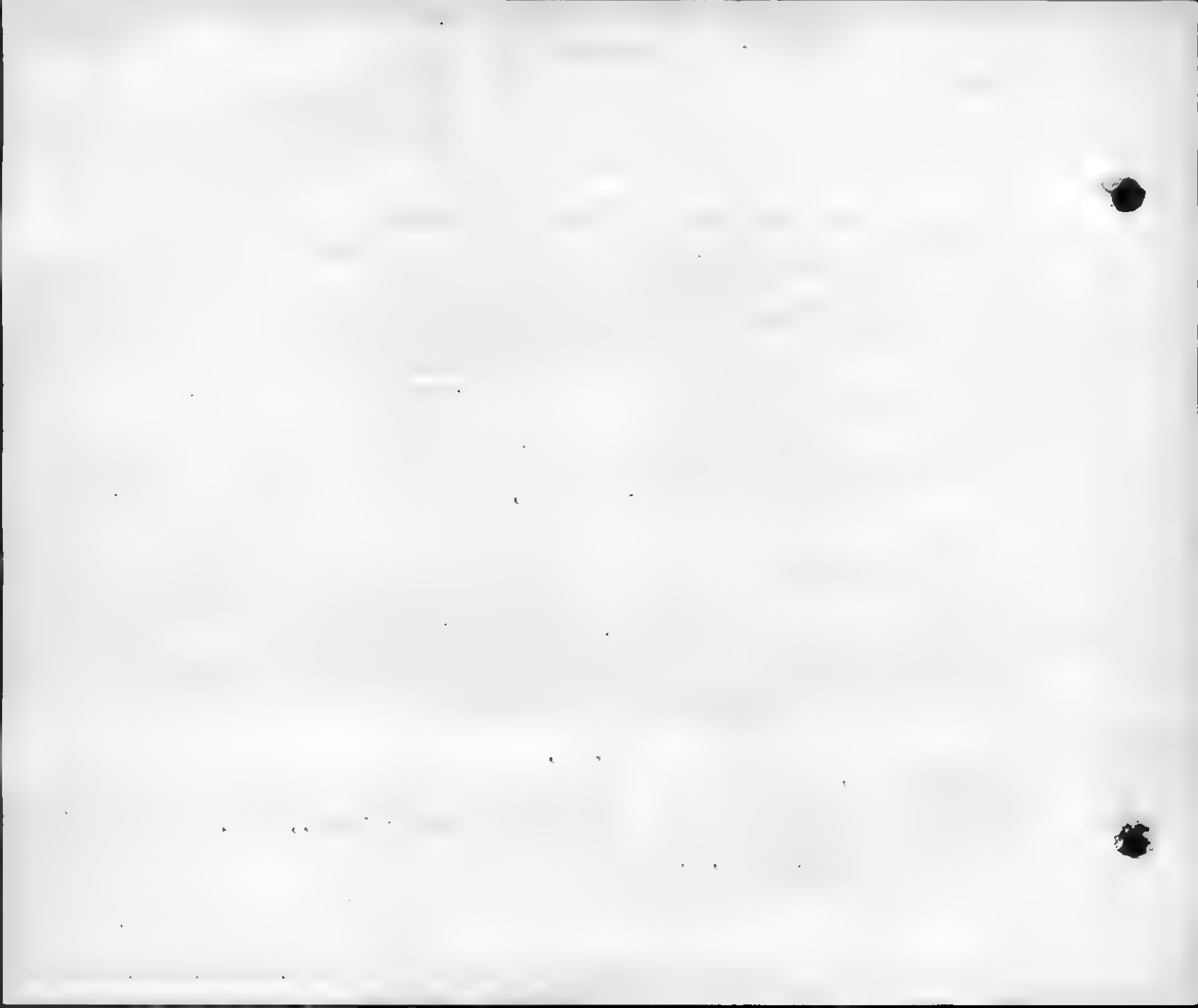
02830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>md.</u> b. COUNTY	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Nursing Home</u>		d. STREET ADDRESS <u>28 Mardrew Road</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH-HOWARD-MEYERS</u>		4. DATE OF DEATH <u>9 Mar 4 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 18, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.O.R.R. Brakeman</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William H. Meyers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Bush</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Norbert A. Meyers</u>		Address <u>28 Mardrew Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia, left</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerotic Cardio-vascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 25, 1959</u> to <u>March 4, 1959</u> , that I last saw the deceased alive on <u>March 3, 1959</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Leo J. Gaver</u>		ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave., Balto. Md.</u>	
PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>		DATE SIGNED <u>3/4/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 6-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Augustine</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Geifel</u>		ADDRESS <u>5311 Edmondson Ave.</u>	
24a. REC'D BY REGISTRAR <u>MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Farris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2842

CERTIFICATE OF DEATH

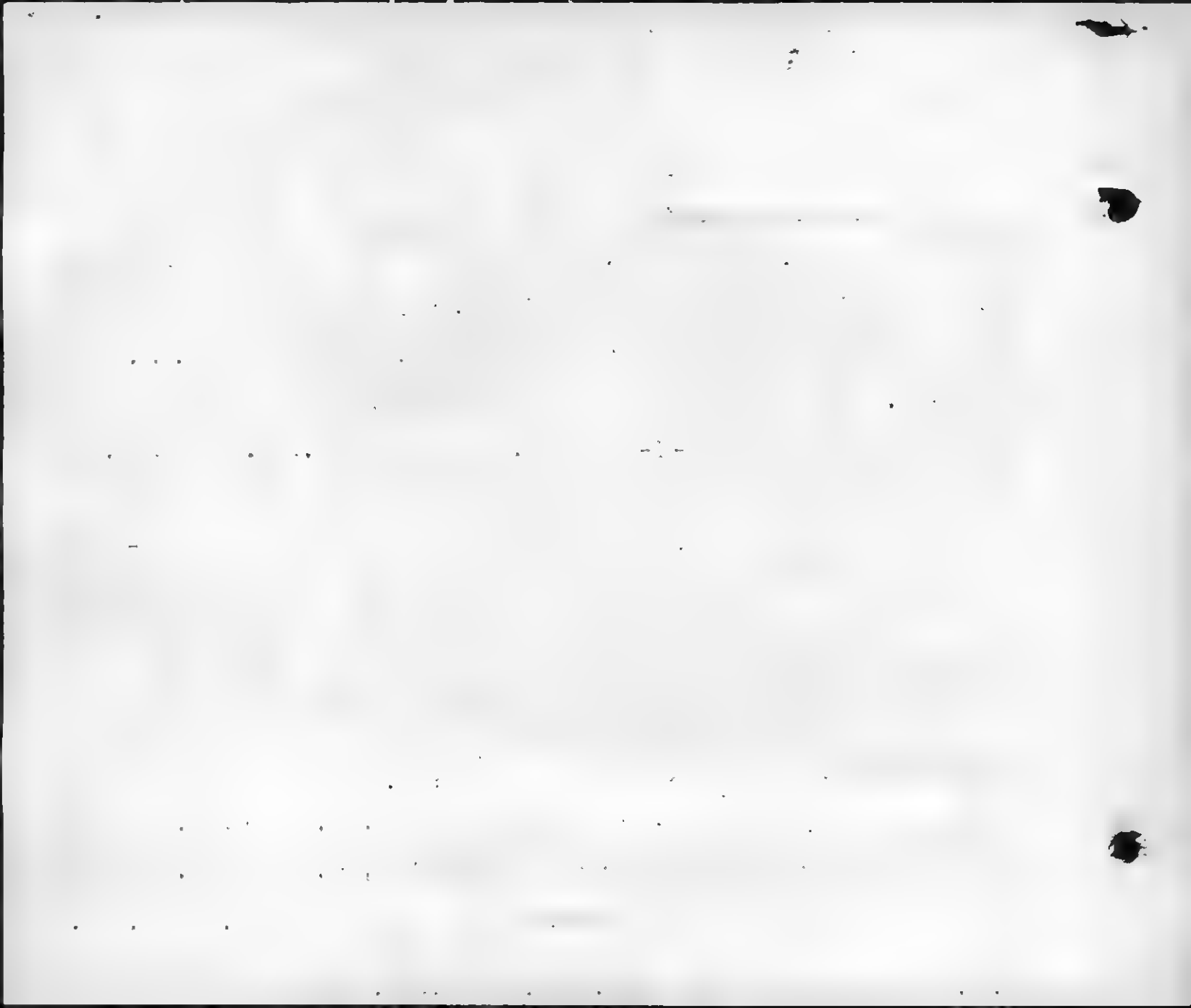
02831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 83 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 4401 Rokeby Road	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last MILLER		4. DATE OF DEATH Month March Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1893
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Miller		14. MOTHER'S MAIDEN NAME Amelia Beckman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 215-03-2536	
17. INFORMANT Clin. Records, VA Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EDEMA (c) CARCINOMA ESOPHAGUS AND LUNGS		INTERVAL BETWEEN ONSET AND DEATH 1 day 1-2 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from December 19, 1958 to March 12, 1959 and that death occurred at 8:20 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) VA Hospital, Ft. Howard, Md. DATE SIGNED 3/12/59			
ACTUAL SIGNATURE George C. McElpatrick		PHYSICIAN'S NAME (Type) GEORGE C. MC ELFATRICK, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) 4430 Balair Rd., Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons		24a. REC'D BY REGISTRAR DATE MAR 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

WM. J. TICKNER & SONS, NORTH & PENNA. AVES., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2843

CERTIFICATE OF DEATH

Reg. Dist. No.

02832

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6303 Mount Ridge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Miller		4. DATE OF DEATH Month March Day 9 Year 1959	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Miller		14. MOTHER'S MAIDEN NAME Mary Hittel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
INFORMANT Address Mrs Jessie O. Miller, 6303 Mount Ridge Rd.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4. DUE TO MYOCARDITIS OF 3 YEARS DURATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 HOURS
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-----------------------------------------------------------------------------------------------------------------------------------	--	------------------------------------------------------------------------------------------------

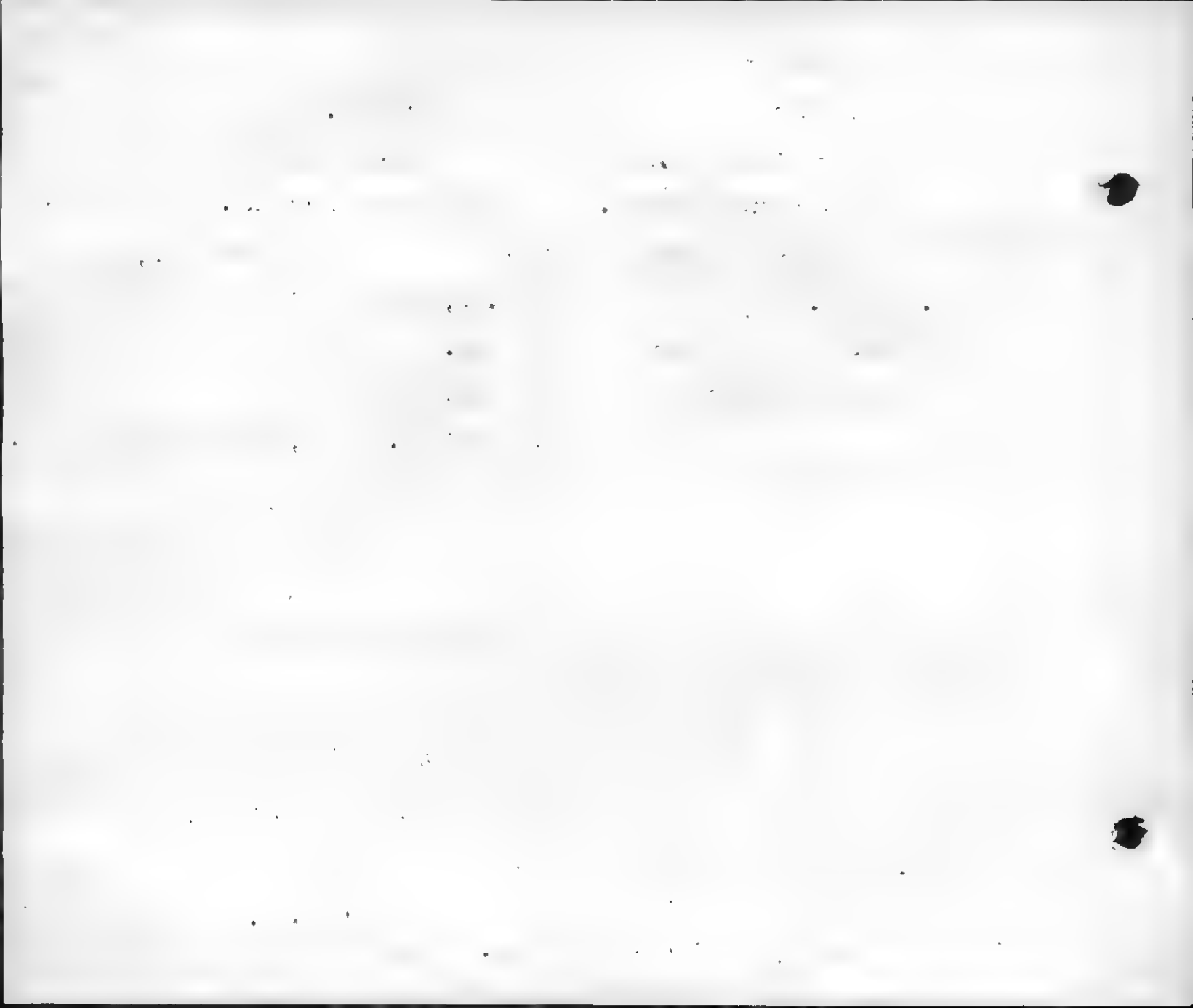
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2 , 1934, to 3/9 , 1959, that I lost saw the deceased alive on 3/9 , 1959, and that death occurred at 8:20 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1011 N. CHARLES ST BALTO MD.	DATE SIGNED
ACTUAL SIGNATURE Charles S. Shanahan M.D.			
PHYSICIAN'S NAME (Type) DAVID S. SHANAHAN M.D.			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/13/59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir.		24a. REC'D BY REGISTRAR 4101 Edmondson Ave.	
		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	DATE MAR 13 '59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

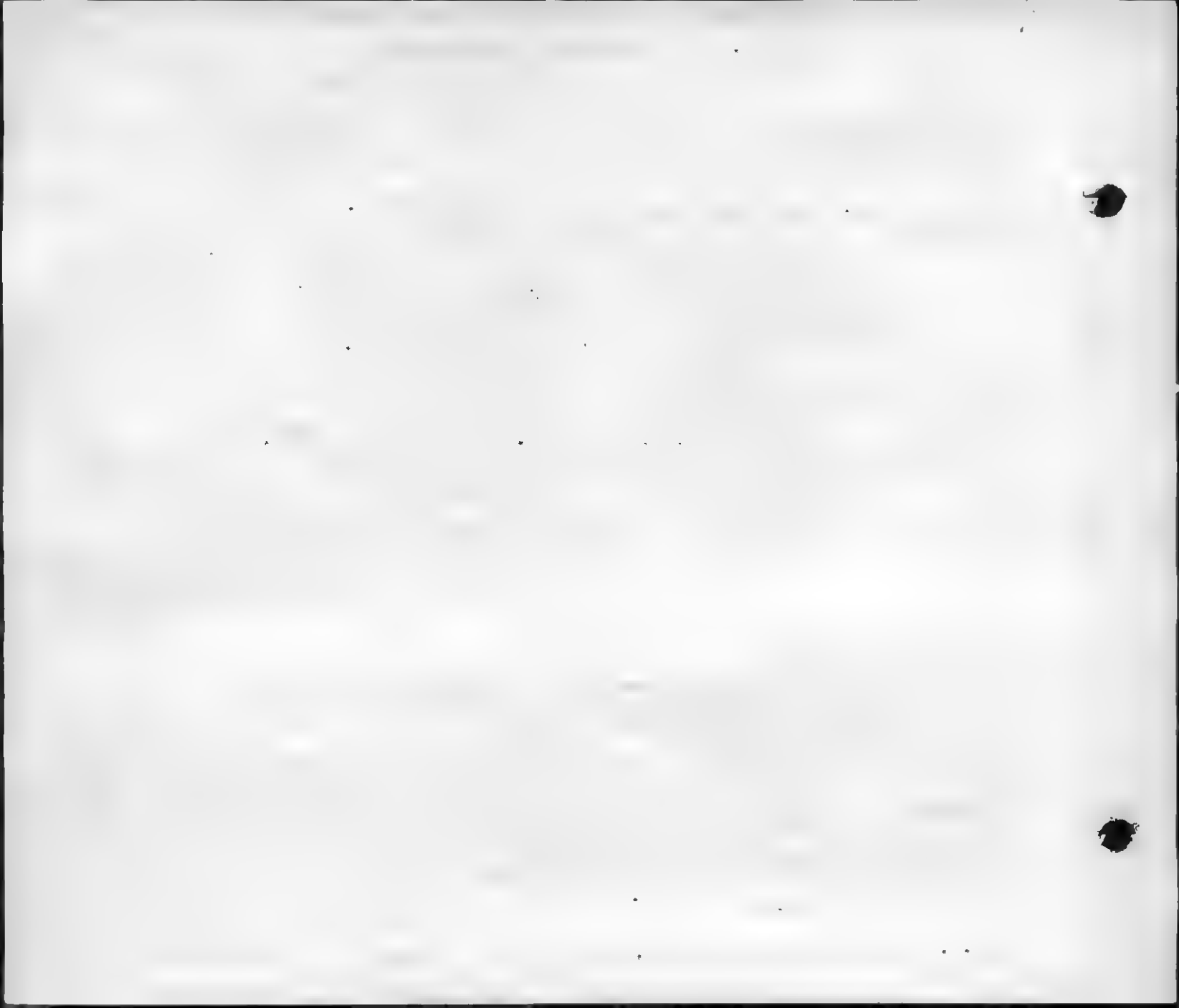
02833

2844

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella c. LENGTH OF STAY IN 1b Oella d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 75 Oella Ave.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella d. STREET ADDRESS 75 Oella Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MERVEL EARL MILLER				4. DATE OF DEATH Month Day Year March 7, 1959 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1903	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woolen Mill		11. BIRTHPLACE (State or foreign country) Timberville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Junie Miller				14. MOTHER'S MAIDEN NAME Minnie Wine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-6161		17. INFORMANT Mrs. Lillian Miller, Oella, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 7 months DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-18-1959 to 3-7-1959 , that I last saw the deceased alive on 2-28-1959 , and that death occurred at 6:50 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Burgdorf M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md		DATE SIGNED 3-7-59	
PHYSICIAN'S NAME (Type) GEORGE E. BURGTOFF M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR DATE MAR 9 1959	
				24b. REGISTRAR'S SIGNATURE Charles L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2845

CERTIFICATE OF DEATH

02834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Herring Hill		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERTA Middle A. Last MILLER		4. DATE OF DEATH Month March Day 18, Year 1959.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1891.
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Mullinix		14. MOTHER'S MAIDEN NAME Amelia Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Arthur F. Miller, Cella, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Adenocarcinoma, uterus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/9/59 , 19 59 , to 18 March , 19 59 , that I last saw the deceased alive on 18 March , 19 59 , and that death occurred at 6 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. Rowe M.D.		ADDRESS (Street, city or town, state) 715 Freshrich Rd	
PHYSICIAN'S NAME (Type) Balto 28, Md		DATE SIGNED 3/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cem.	22d. LOCATION (City, town, or county) (State) Elkridge, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Boston Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE MAR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

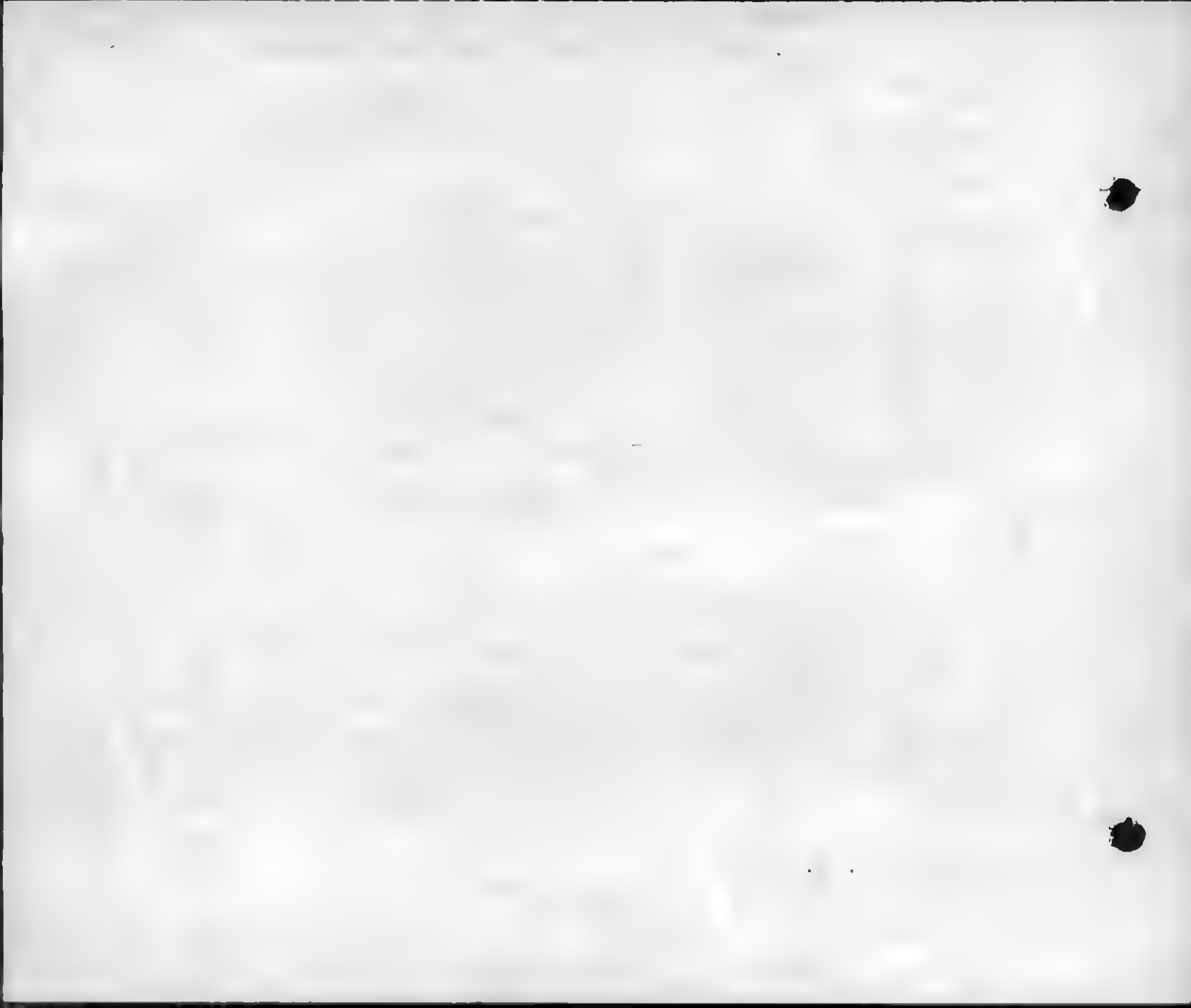
02835

2846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN TB 26 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Park Heights Avenue				d. STREET ADDRESS Park Heights Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theresa Middle Hattie Last Miller				4. DATE OF DEATH Month March Day 29 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 1 1914		9. AGE (in years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W Springman				14. MOTHER'S MAIDEN NAME Hedwig Theresa Zurin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-20-4198		17. INFORMANT Address Mills Md Mrs Emma Lepka 15 Cedarmere Rd Owings			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 hrs.							
MEDICAL CERTIFICATION							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Conley				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Conley				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 3-31-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 1 1959		22c. NAME OF CEMETERY OR CREMATORY Evergreen Gardens Cem		22d. LOCATION (City, town, or county) (State) Finksburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Reisterstown Md				24a. REC'D BY REGISTRAR DATE APR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02836

2847

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 28 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS Seven Gables Road			
3. NAME OF DECEASED (Type or print) First HERMAN Middle E. Last MITCHELL				4. DATE OF DEATH Month March Day 6 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1894	
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Naval Air Station			
13. FATHER'S NAME James A. Mitchell				14. MOTHER'S MAIDEN NAME Rose Edna Farwicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO 216-07-8680		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from February 6, 1959 , to March 6, 1959 and that death occurred at 12:28 M. from the causes and on the date stated above			
ACTUAL SIGNATURE Chien Wei Lan				ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				DATE SIGNED 3/6/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons				24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH.

Reg. Dist. No.

02648

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENLAND BE.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENLAND BE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GREENLAND BE. RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Christopher Morck</u>		4. DATE OF DEATH <u>MARCH 27 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 13 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIRE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>
13. FATHER'S NAME <u>CARL MORCK</u>		14. MOTHER'S M maiden NAME <u>Helen McARDIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1916-1914</u>		17. INFORMANT <u>ELISABETH H. COOK</u> Address <u>9209 Lombard St. Silver Spring, Md.</u>	
16. SOCIAL SECURITY NO. <u>215-073179</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>			
DUE TO (b) <u>Pulmonary Edema</u>			
DUE TO (c) <u>BRONCHOGENIC CARCINOMA</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>—</u> <u>19</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/14 1948</u> to <u>3/27 1959</u> , that I last saw the deceased alive on <u>3/27 1959</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Prichard</u>		DATE SIGNED <u>3/27/59</u>	
PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD M.D.</u>		ADDRESS (Street, city or town, state) <u>715 Corree Rd Glen Burnie, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	22b. DATE THEREOF <u>4/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>Balt.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Thumel</u>		ADDRESS <u>Home</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	

130 E. Fort Ave.

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 of this certificate must be filed with the attending physician and the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, it must be filed with the registrar. Pages 3 and 4 of this certificate may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uppercus (Rural)</u>		c. LENGTH OF STAY IN 1b <u>80</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>HARRY S. MORFOOT</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 19, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Surveyor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Morfoot</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cullison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>220-05-0413</u>	
17. INFORMANT <u>Harry W Morfoot</u>		Address <u>Uppercus, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 12</u> , 19 <u>55</u> , to <u>March 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 12</u> , 19 <u>59</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		ADDRESS <u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw L. Lipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2710

CERTIFICATE OF DEATH

02838
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Baltimore Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle (NMN) Last Mossa		4. DATE OF DEATH Month March Day 3 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27th, 1882
9. AGE (in years last birthday) 76		10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Achile Fabbri		14. MOTHER'S MAIDEN NAME Victoria Cavazutti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT J.W. Bianchi		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease DUE TO Diabetes mellitus (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 hr 15 yrs 8 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 23 , 19 44 , to 3-3 , 19 59 , that I last saw the deceased alive on 3-3 , 19 59 , and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Mornington Rd DATE SIGNED 3-3-59			
ACTUAL SIGNATURE Eugene F Nery		M.D. 7001 Mornington Rd	
PHYSICIAN'S NAME (Type) Eugene F Nery		M.D. Dundalk 22, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/6/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		ADDRESS Dundalk 22	
24a. REC'D BY REGISTRAR DATE MAR 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2849

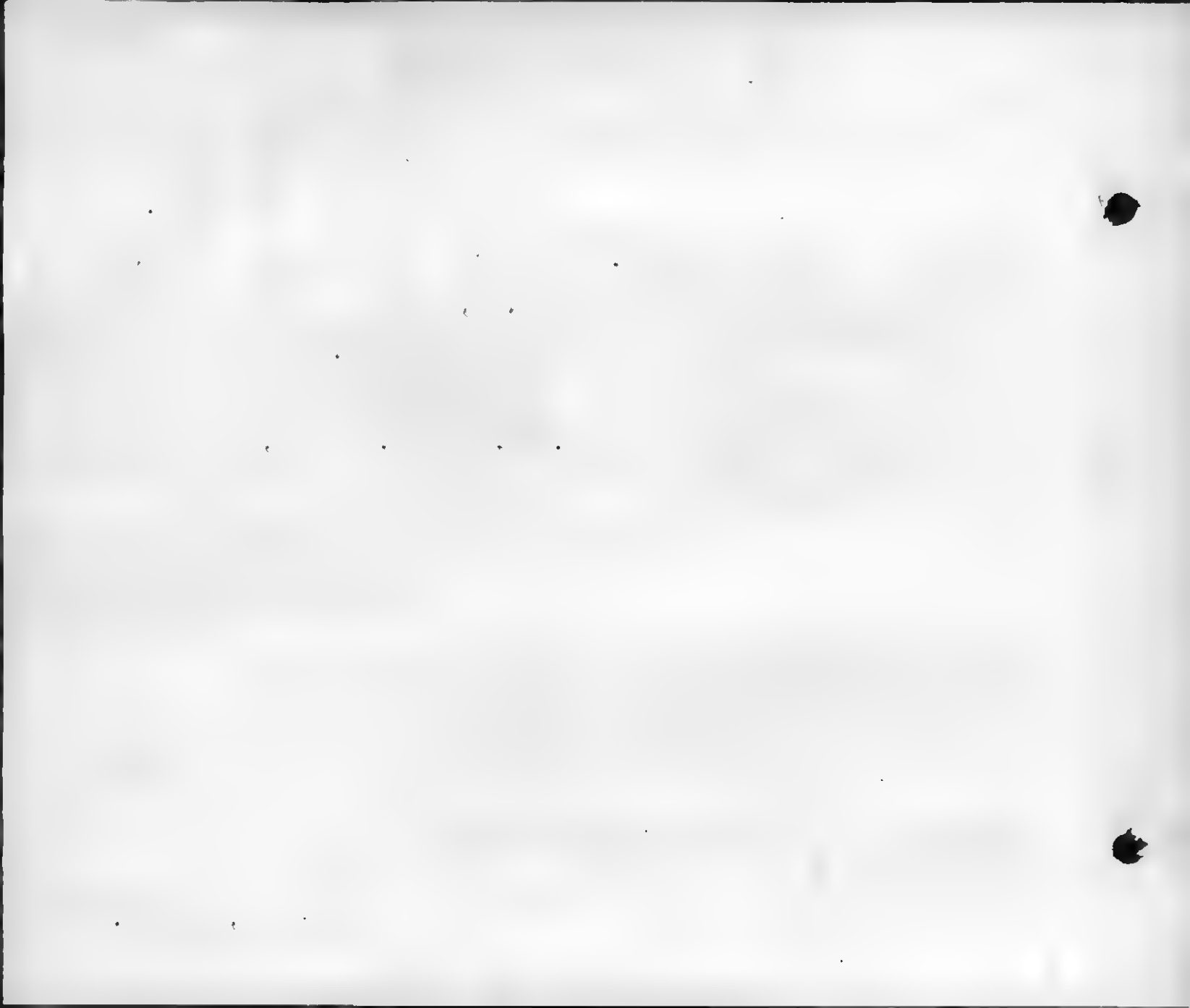
CERTIFICATE OF DEATH

02839

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa		e. STREET ADDRESS Homewood Apts Charles & 31st Sts.	
3 NAME OF DECEASED (Type or print) First Mary Middle C. Last Nelligan		4. DATE OF DEATH Month March Day 21 Year 19 59	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 28, 1866
9 AGE (In years last birthday) yrs 92		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Dennis Hogan		14 MOTHER'S MAIDEN NAME Mary Craven	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Rt. Rev. Joseph W. Nelligan, Balto & Ware Aves		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hydrocephalus - senile (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1956 to March 21, 1959 that I last saw the deceased alive on March 21, 1959 , and that death occurred at 11 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Medical Apts Bldg DATE SIGNED 3/25/59			
ACTUAL SIGNATURE J. Emmett Green M.D.		PHYSICIAN'S NAME (Type) J. EMMETT GREEN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23 FUNERAL DIRECTOR'S SIGNATURE H. W. Means & Son 805 N. Calvert St.		24a. REC'D BY REGISTRAR DATE MAR 26 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02840

2850 Item 9 Film 239 3-16-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>catonsville</u>	
c. LENGTH OF STAY IN TB <u>1 day</u>		d. STREET ADDRESS <u>1111 N. ...</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. ...</u>		e. STREET ADDRESS <u>1111 N. ...</u>	
3. NAME OF DECEASED (Type or print) <u>John ...</u>		4. DATE OF DEATH <u>March 10 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-92</u>
9. AGE (In years last birthday) <u>66</u>		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry ...</u>		14. MOTHER'S MAIDEN NAME <u>...</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>...</u>	
17. INFORMANT <u>...</u>		Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>...</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>...</u> DUE TO <u>...</u> (c) <u>...</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>...</u>			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>...</u>		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>...</u>		DATE SIGNED <u>Mar 9 59</u>	
EXAMINER'S NAME (Type) <u>...</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. RURAL CREMATION, REMOVAL (Specify) <u>...</u>		22b. DATE THEREOF <u>3-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>...</u>		22d. LOCATION (City, town, or county) (State) <u>...</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>...</u>		ADDRESS <u>...</u>	
24a. REC'D BY REGISTRAR <u>...</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	
DATE <u>MAR 10 '59</u>		Signature <u>...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2851

CERTIFICATE OF DEATH

Reg. Dist. No.

02841

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 c. LENGTH OF STAY IN lb 33 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore City d. STREET ADDRESS 5809 Clover Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tillie Middle Nusbaum Last Nusbaum				4. DATE OF DEATH Month March Day 28 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/71	
9. AGE (In years last birthday) 88 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Baltic Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME not known Isaac				14. MOTHER'S MAIDEN NAME Ira Rosenberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT Irvin Nusbaum - 6907 Dorset Place			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) malnutrition						INTERVAL BETWEEN ONSET AND DEATH Several years Several years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to 9-28-59 , 19 59 , that I last saw the deceased alive on 3-28-59 , 19 59 , and that death occurred at 11:55AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Eugene Wa ermann				ADDRESS (Street, city or town, state) Spring Grove State Hosp.		DATE SIGNED 3-28-59	
PHYSICIAN'S NAME (Type) C. Eugene Wa ermann							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-30-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				ADDRESS 2100 Euteria Pl		24a. REC'D BY REGISTRAR MAR 30 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

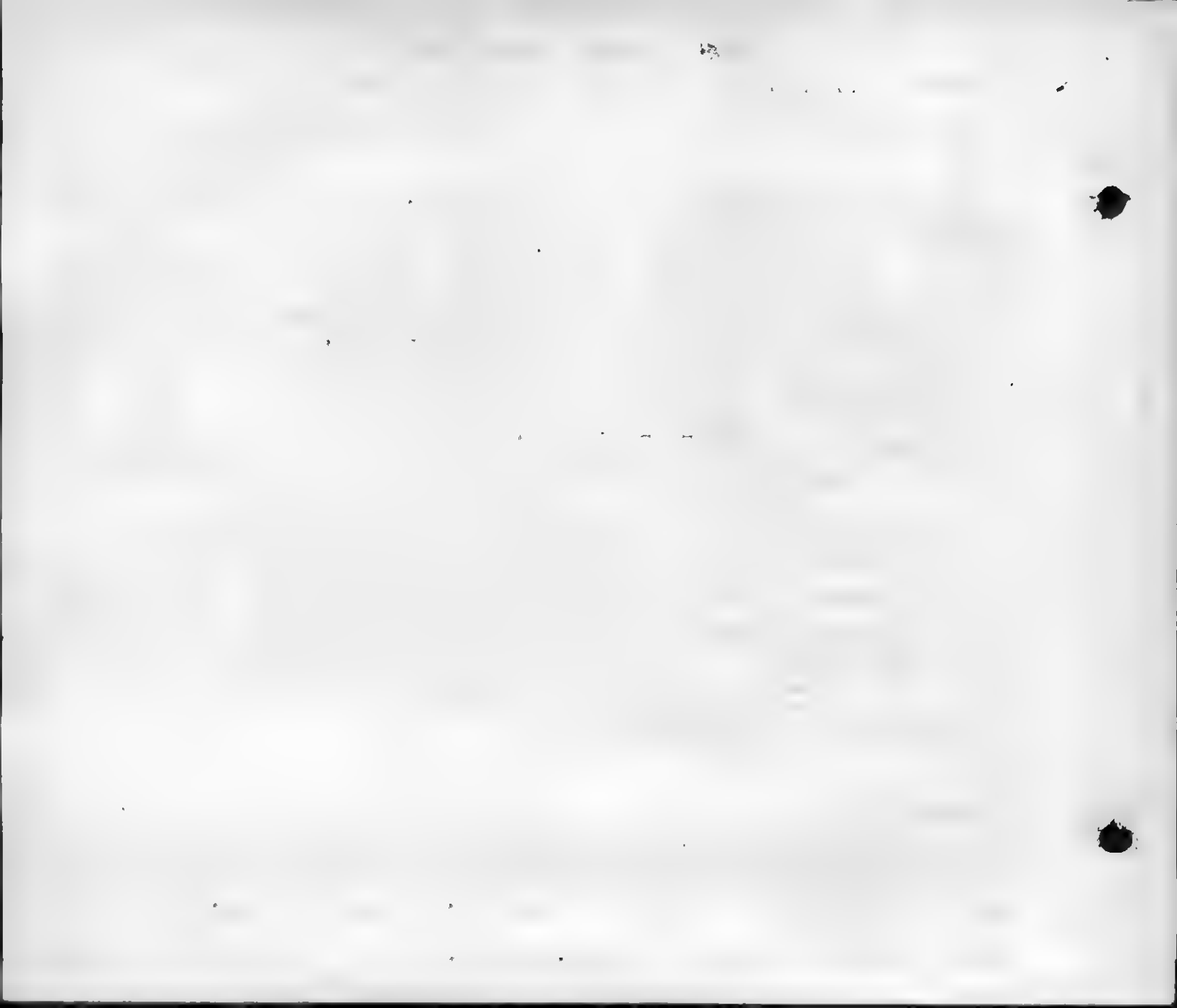
2852

CERTIFICATE OF DEATH

02842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>CATONSVILLE</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>286</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>7 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in The Pines</u>		d. STREET ADDRESS <u>3023 W. Belvedere Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Angelina</u> Middle <u>Palumbo</u> Last <u>Palumbo</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17-1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife (tailor)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Palermo-Italy.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>		13. FATHER'S NAME <u>Giovanni Cremona</u>		14. MOTHER'S MAIDEN NAME <u>GLELIA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-0455</u>		17. INFORMANT Address <u>Mrs. Joseph D'Onofrio 1703 INGRAM P.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>77mo.</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiparesis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>8-27-1958</u> , to <u>3-12-1959</u> , that I last saw the deceased alive on <u>3-12-1959</u> , and that death occurred at <u>3:42 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>William K. Gallagher</u>		M.D. <u>6209 Frederick Ave.</u>		DATE SIGNED <u>3/13/59</u>	
PHYSICIAN'S NAME (Type) <u>William K. Gallagher</u>		<u>Catonville-28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank R. Della Noce</u>		ADDRESS <u>322 S. High St.</u>		24a. REC'D BY REGISTRAR <u>DATE 16 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2853

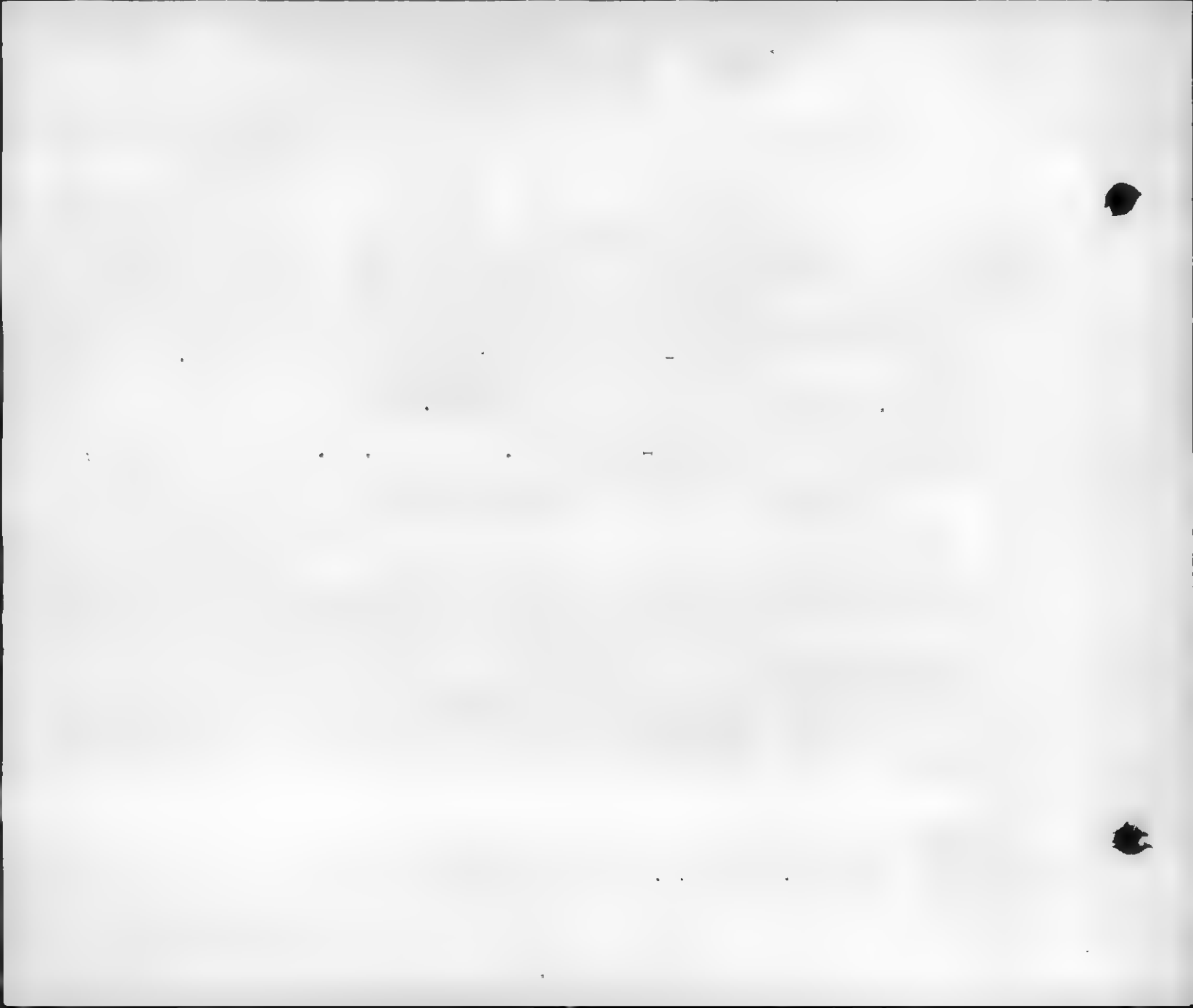
CERTIFICATE OF DEATH

02843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
c. LENGTH OF STAY IN 1b <u>3 Days</u>		d. STREET ADDRESS <u>2037 Dorsey Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>L</u> Last <u>PARKER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1885</u>
9. AGE (In years last birthday) <u>73 68</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Dodge City, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George W. Parker</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Bailey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO <u>218-146 6413</u>	
17. INFORMANT <u>Clin. Records, Vet. Adm. Hospital, Ft Howard, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUPPURATIVE LOBULAR PNEUMONIA</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 11</u> , 1959, to <u>March 14</u> , 1959, and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D.		DATE SIGNED <u>3/16/59</u>	
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>		<u>VAH Ft Howard, Md</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City town or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM Cook</u>		24a. REC'D BY REGISTRAR <u>Blight Inc</u>	
ADDRESS <u>6009 Harford Rd Balto. Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

12844

2854

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sweet Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sweet Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phoenix RD</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Holmes</u> First <u>Perdue</u> Middle Last				4. DATE OF DEATH <u>March</u> Month <u>5</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1979</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Marquette MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Perdue</u>				14. MOTHER'S MAIDEN NAME <u>ATTIE Holmes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-03-9716</u>		17. INFORMANT <u>Mrs Wm B. Buckingham</u>		Address <u>Baltimore 1 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis</u> (c) <u>Arterio-Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 5, 1930</u> , to <u>March 5, 1959</u> , that I last saw the deceased alive on <u>March 5, 1959</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter M. Hammett</u> M.D.				ADDRESS (Street, city or town, state) <u>Baltimore</u>			
PHYSICIAN'S NAME (Type) <u>Walter M. Hammett</u>				DATE SIGNED <u>Baltimore</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 7-59</u>		<u>St James</u>		<u>Marquette Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Marquette & Co. 1400 E. Pratt St. Baltimore, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02845

2855

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 S. MARLYN CEM.</u>				d. STREET ADDRESS <u>102 S. MARLYN AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS D. PICKENS</u>				4. DATE OF DEATH Month Day Year <u>MARCH 5 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-06</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILWAY MAIL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POCONO CHIE</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SPILL PICKENS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET PICKENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MARGARET PICKENS 102 S. MARLYN AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 1955, to <u>March 5</u> , 1959, that I last saw the deceased alive on <u>March 2</u> , 1959, and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Lyden</u> M.D.				ADDRESS (Street, city or town, state) <u>815 Eastern Ave</u>		DATE SIGNED <u>3/6/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, MD</u>				<u>St. E 21, 2d.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CAR. LINDEN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u> ADDRESS <u>48 Eastern Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



2856

CERTIFICATE OF DEATH

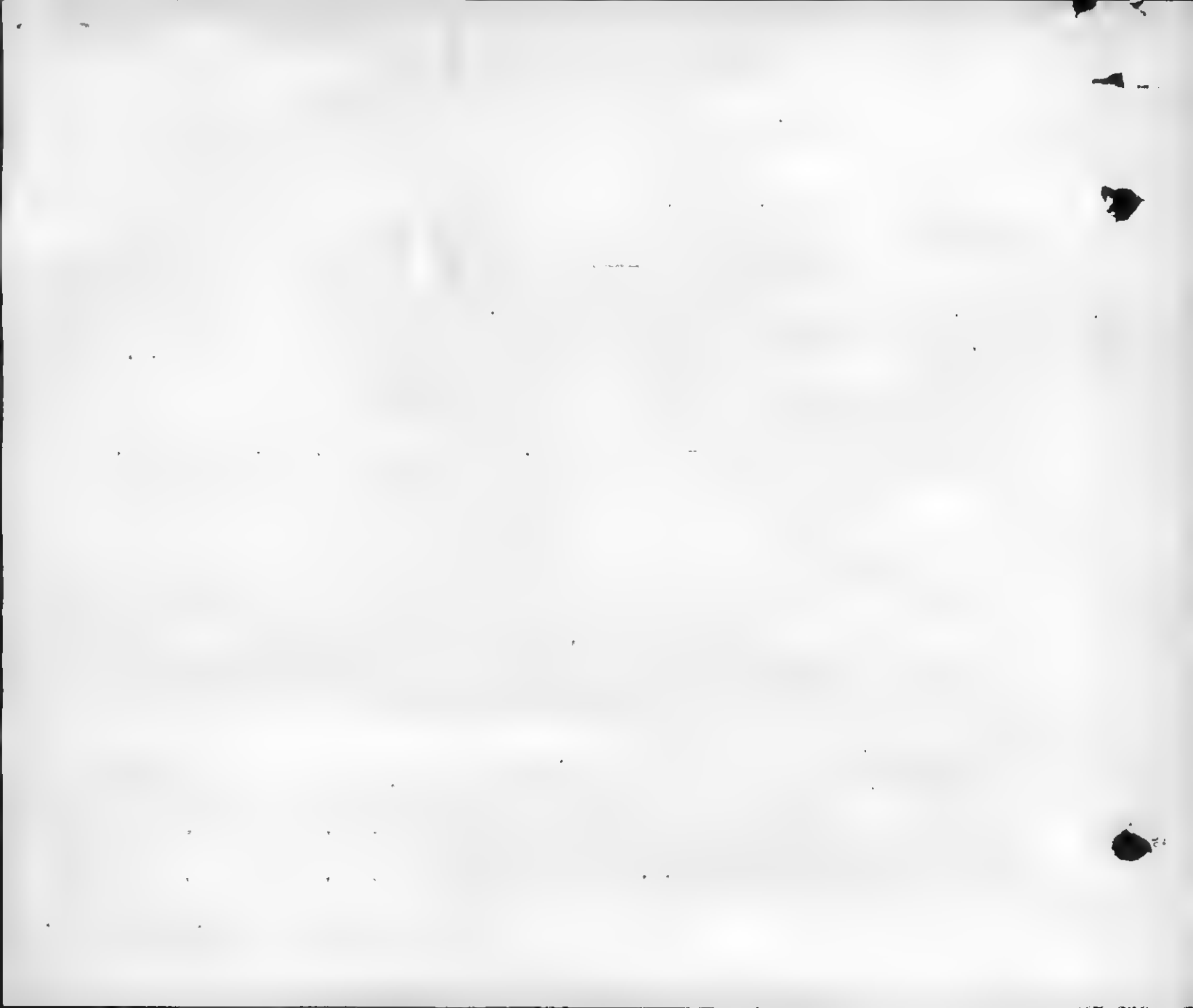
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY /	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle PLIMACK Last PLIMACK		4. DATE OF DEATH Month March Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1892
9. AGE (in years last birthday) yrs 67		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring Shop	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Isaac Plimack		14. MOTHER'S MAIDEN NAME Jennie Silverman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 215-32-8161	
17. INFORMANT Clin. Records, VA Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, PAGET'S DISEASE			INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4, 1959 , to March 7, 1959 , and that death occurred at 5:45 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED VA Hospital, Ft. Howard, Md. 3/7/59			
ACTUAL SIGNATURE William S. Kiser M.D.		DATE SIGNED 3/7/59	
PHYSICIAN'S NAME (Type) WILLIAM S. KISER, M.D.		VA Hospital, Ft. Howard, Md. 3/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-10-59	22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery	22d. LOCATION (City, town, or county) (State) 8801 Frederick Rd., Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Rd. Randallstown, Md.	24a. REC'D BY REGISTRAR DATE MAR 12 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

LORING BYERS FUNERAL DIRECTOR 8728 Liberty Rd Balto Md Randallstown, Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reloaded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02847

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

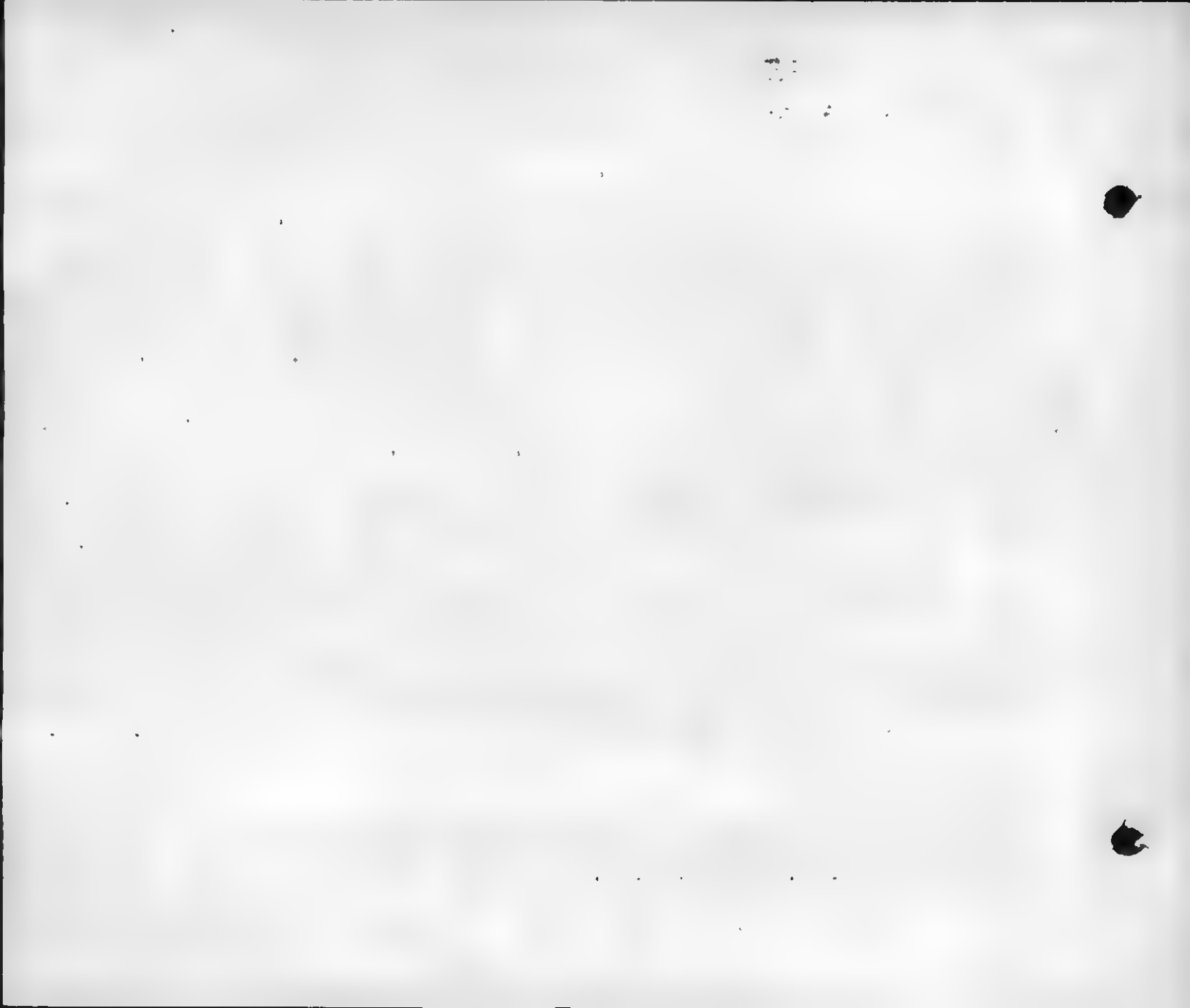
2857

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		/d STREET ADDRESS <u>3700 Coronada Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Petro Frank Provenzano</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>November 27, 1907</u>	9. AGE (In years last birthday) <u>51</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoes</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
13. FATHER'S NAME <u>Frank Provenzano</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Veneziano</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Evelyn P. Provenzano</u>		Address <u>Pikesville 8, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot thru head (self inflicted)</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mental Depression</u> DUE TO (c)			<u>5 min.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Shot thru head (self inflicted)</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> <u>PM</u> <u>3/25/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Milford Dump</u>	20f. (City or town) (County) (State) <u>Pikesville Balto. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		DATE SIGNED <u>3-27-59</u>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 30 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>



2853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
1 Item 1 FILE 6240 4-2-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Mt. Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Field - rear of 6123 Falls Road		e. STREET ADDRESS Hollins Avenue	
3. NAME OF DECEASED (Type or print) LEE		4. DATE OF DEATH March 23 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN
9. AGE (In years last birthday) 33 yrs		10. IF UNDER 1 YEAR: Months 3 Days 23 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY S.C.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gibb Regan		14. MOTHER'S MAIDEN NAME Cora Brunson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Regan		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia.			
490X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORY Summerton S.C.		22d. LOCATION (City, town, or county) (State) Summerton S.C.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Holbert		ADDRESS 918 David Hill Ave	
24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2, Film G241, 4/11/59
CERTIFICATE OF DEATH

02849

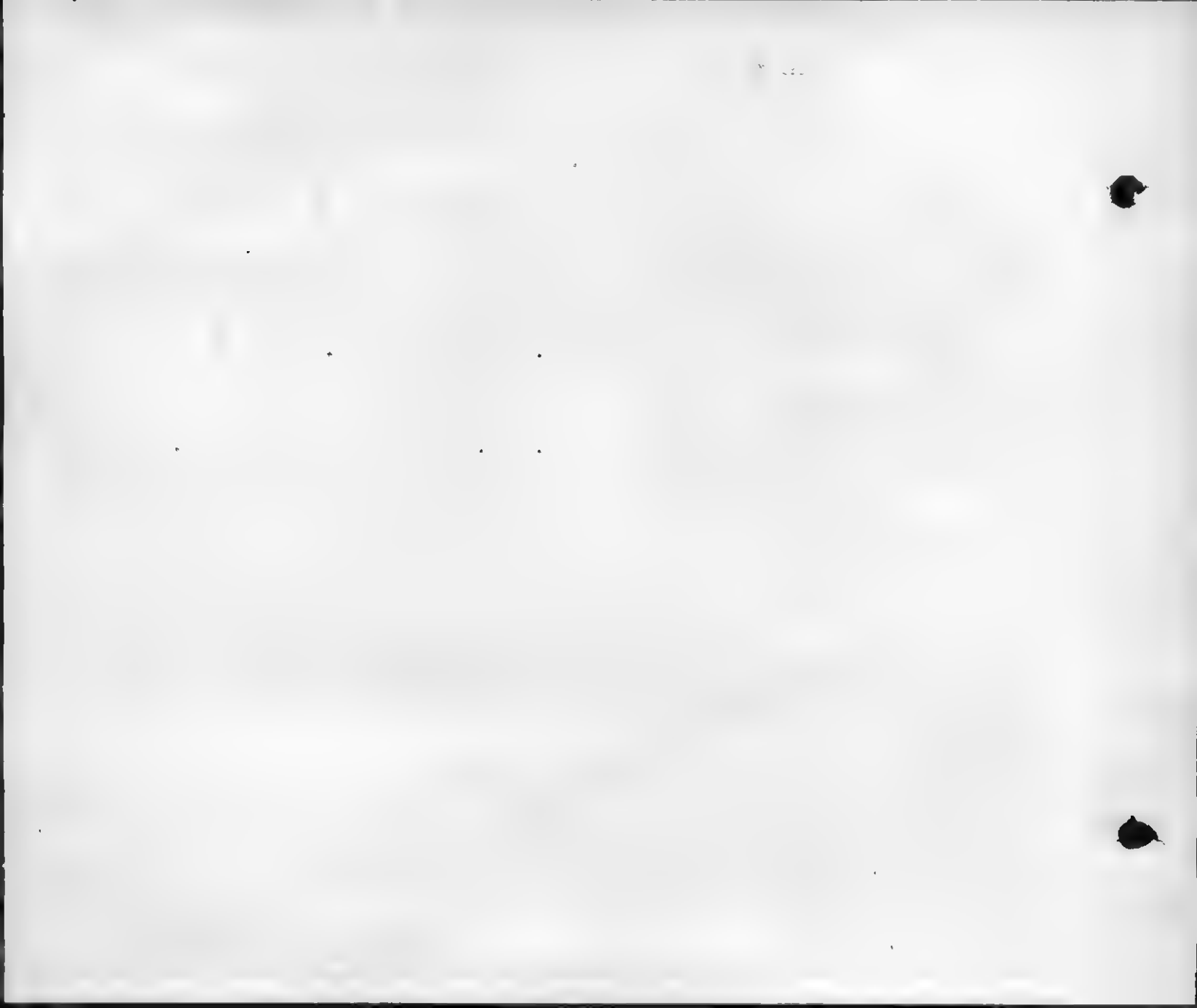
Reg. Dist. No.

2859

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roseville Livingston	
c. LENGTH OF STAY IN 1b 4 1/2 yrs.		d. STREET ADDRESS 31 Collinwood Road 314 Gadsden St. Elyria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAY WILLIAM REWALT		4. DATE OF DEATH Month Day Year March 29, 1959 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist- retired		10b. KIND OF BUSINESS OR INDUSTRY Retail Drug Prop.	
11. BIRTHPLACE (State or foreign country) Middletown, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Rewalt		14. MOTHER'S MAIDEN NAME Mary Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Hon. deS. Barnes, Phoenix, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized & cerebral arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-7 , 19 55 to 3/27/59 , 19 59 , that I last saw the deceased alive on 3-27 , 19 59 , and that death occurred at 1:07 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4-2-59 DATE SIGNED			
ACTUAL SIGNATURE Ernest C. Brown Jr. M.D.		1101 North Calvert Street, Baltimore 2.	
PHYSICIAN'S NAME (Type) Dr. Ernest C. Brown, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Middletown Cemetery	22d. LOCATION (City, town or county) (State) Middletown, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE APR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

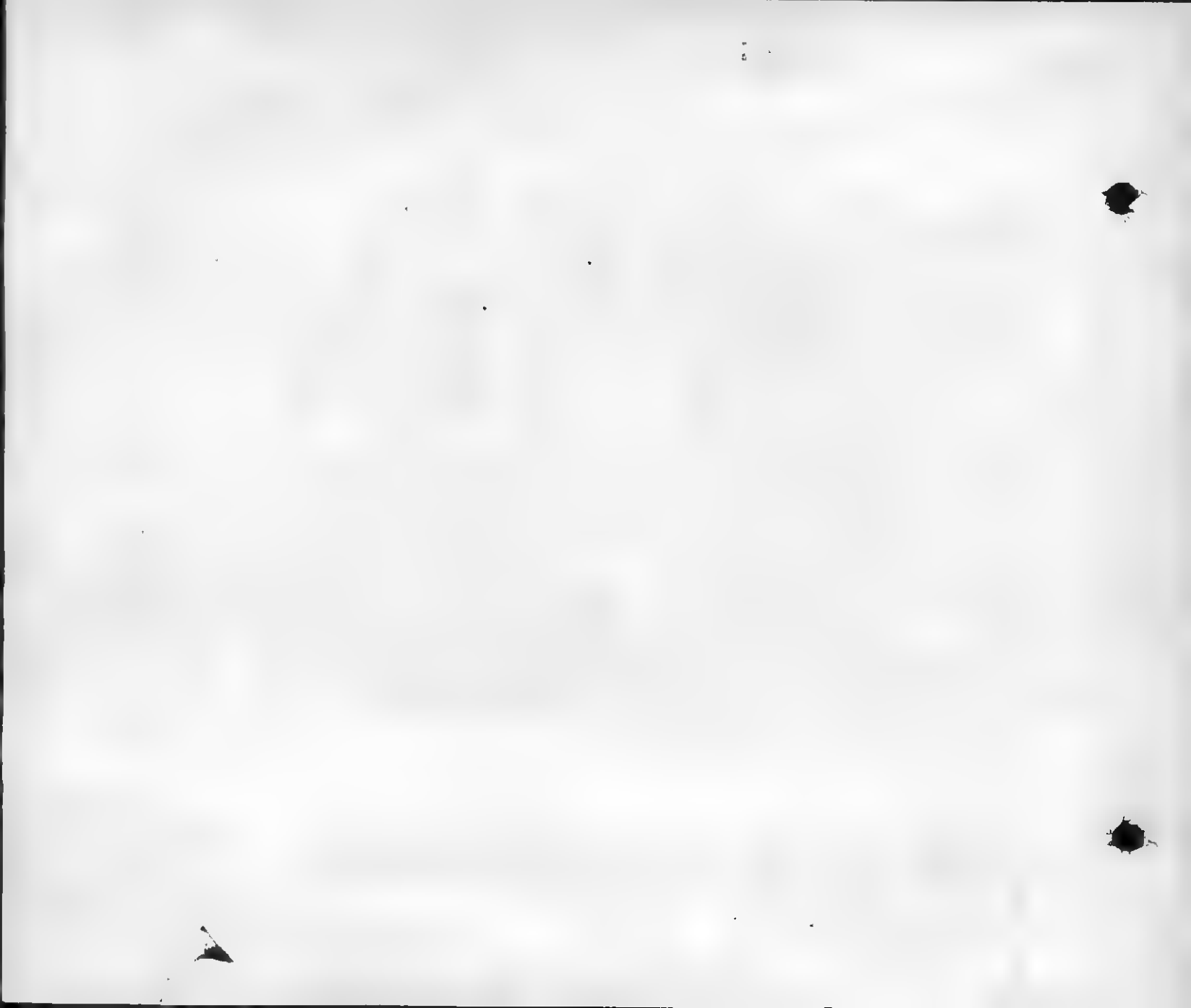
02850

2860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hampton Lane</u>				d. STREET ADDRESS <u>Hampton Lane</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN RIDGELY, JR.</u>				4. DATE OF DEATH Month Day Year <u>March 6, 1959</u> <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1882</u>	9. AGE (in years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Ridgely</u>				14. MOTHER'S MAIDEN NAME <u>Helen Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Family records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunsnot Wound of Heart</u> DUE TO (b) <u>From 38 Calibre Pistol</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Sudden</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hampton Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REG. STRA. SIGNATURE <u>C. L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2861

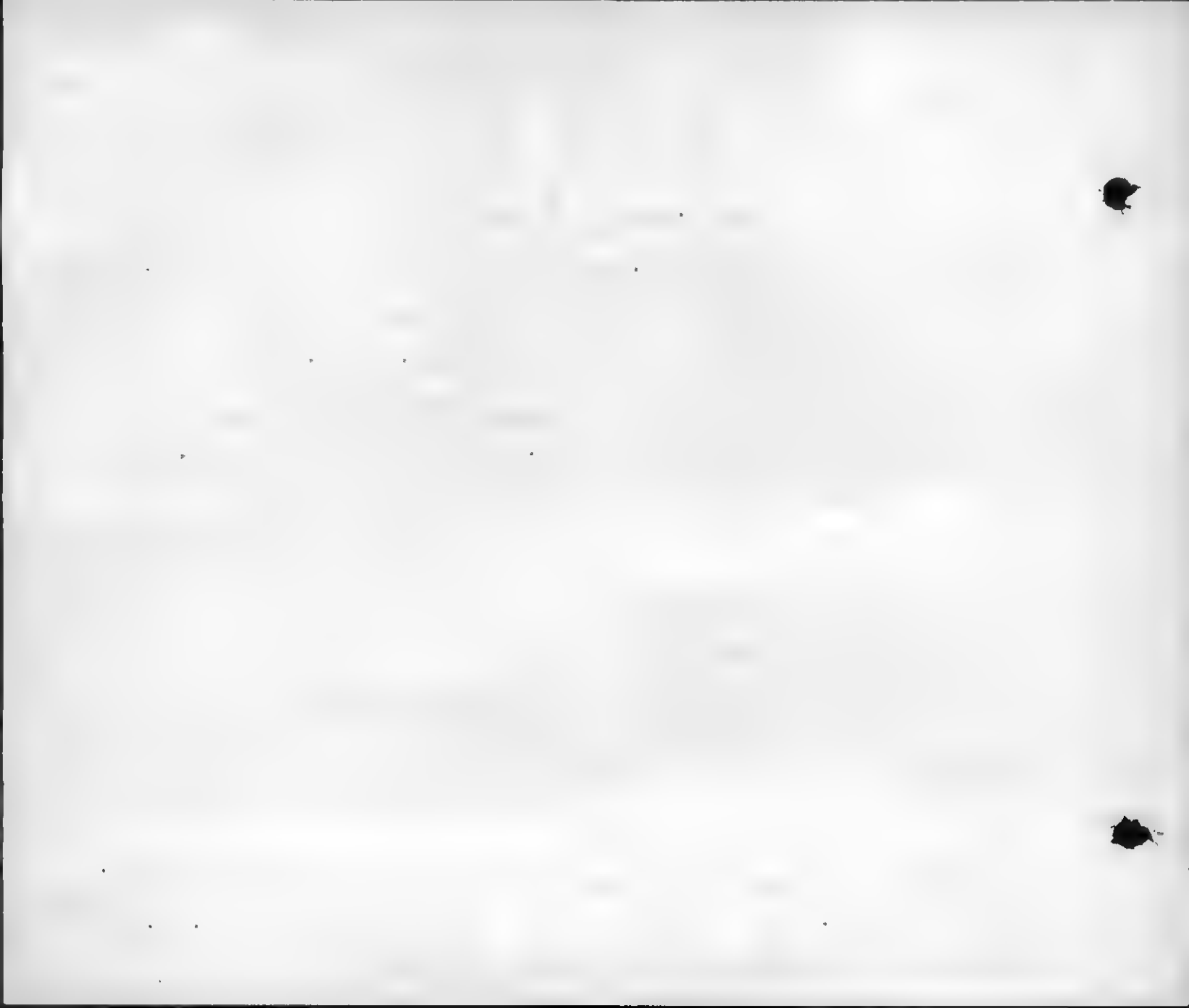
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before adm sion) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7008 Beech Ave.		e. STREET ADDRESS 7008 Beech Ave.	
3. NAME OF DECEASED (Type or print) First Susie Middle M. Last Robertson		4. DATE OF DEATH Month March Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Clayton		14. MOTHER'S MAIDEN NAME Sarah DeMoss	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Henry DeValk		Address 7008 Beech Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROSIS, GENERALIZED DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 7 hours 20 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-18 , 19 49 , to 3-8 , 19 59 , that I last saw the deceased alive on 6-2 , 19 56 , and that death occurred at 6:30 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Gordon G. Lewis M.D. PHYSICIAN'S NAME (Type) Allen G. Swiss, M.D. (232 Belair Road - Baltimore 6, Md.)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 11, 1959	22c. NAME OF CEMETERY OR CREMATORY Fork Methodist	22d. LOCATION (City, town, or county) (State) Fork, Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd	24a. REC'D BY REGISTRAR DATE MAR 11 '59
		24b. REGISTRAR'S SIGNATURE William D. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



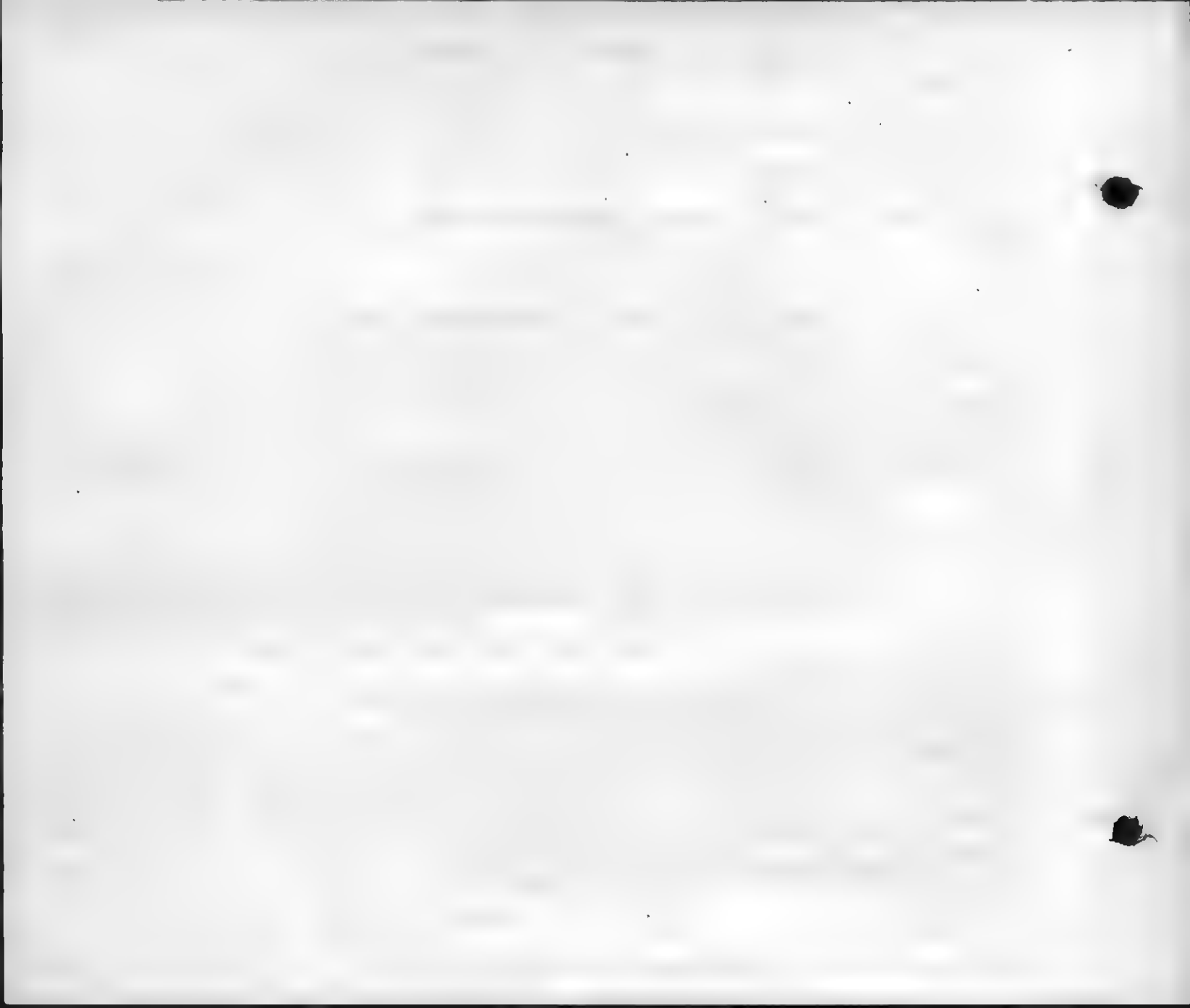
2862
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-ROCKDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-ROCKDALE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3214 MAYFIELD AVE				d. STREET ADDRESS 3214 MAYFIELD AVE.			
3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last ROGERS				4. DATE OF DEATH Month March Day 27 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 28, 1884	9. AGE (In years last birthday) 75	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY CLERK - CHURCH		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES C. ROGERS				14. MOTHER'S MAIDEN NAME KATHERINE W. ROTTEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 21-05-6681		17. INFORMANT MRS. OGLE - DAUGHTER		Address 3214 MAYFIELD BALTO. 7, MD. AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC NEPHRITIS DUE TO (c) EMPHYSEMA				INTERVAL BETWEEN ONSET AND DEATH 10 YEARS 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY , 19 59 , to MARCH 27 , 19 59 , that I last saw the deceased alive on MARCH 20 , 19 59 , and that death occurred at 12:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L. Pierpont				ADDRESS (Street, city or town, state) 8204 LIBERTY RD, BALTO. 7, MD.			
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.				DATE SIGNED 3/27/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jackson & Sons				ADDRESS Bethesda - 12, Md.		24a. REC'D BY REGISTRAR MAR 30 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2863 **CERTIFICATE OF DEATH**

02853

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thesville</u>		c. LENGTH OF STAY (In 1b)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V - 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Torleigh Nursing Home</u>				d. STREET ADDRESS <u>5612 Wesley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First, <u>Regina</u> , Middle, <u>Rudolph</u> , Last, <u></u>				4. DATE OF DEATH Month <u>3</u> - Day <u>7</u> - Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1905</u>		9. AGE (In years last birthday) <u>53</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Phila., Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hyman</u>				14. MOTHER'S MAIDEN NAME <u>Clara</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Aaron Rudolph - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of left kidney</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 29, 1958</u> to <u>Mar. 7, 1959</u> , that I last saw the deceased alive on <u>Feb. 26, 1959</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Abraham B. Hurwitz</u> M.D.				ADDRESS (Street, city or town, state) <u>3403 Garrison Blvd.</u>		DATE SIGNED <u>3/8/59</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ, M.D. Baltimore 15 Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-9-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lauri Inc. - 2100 Eaton Place</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return page 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

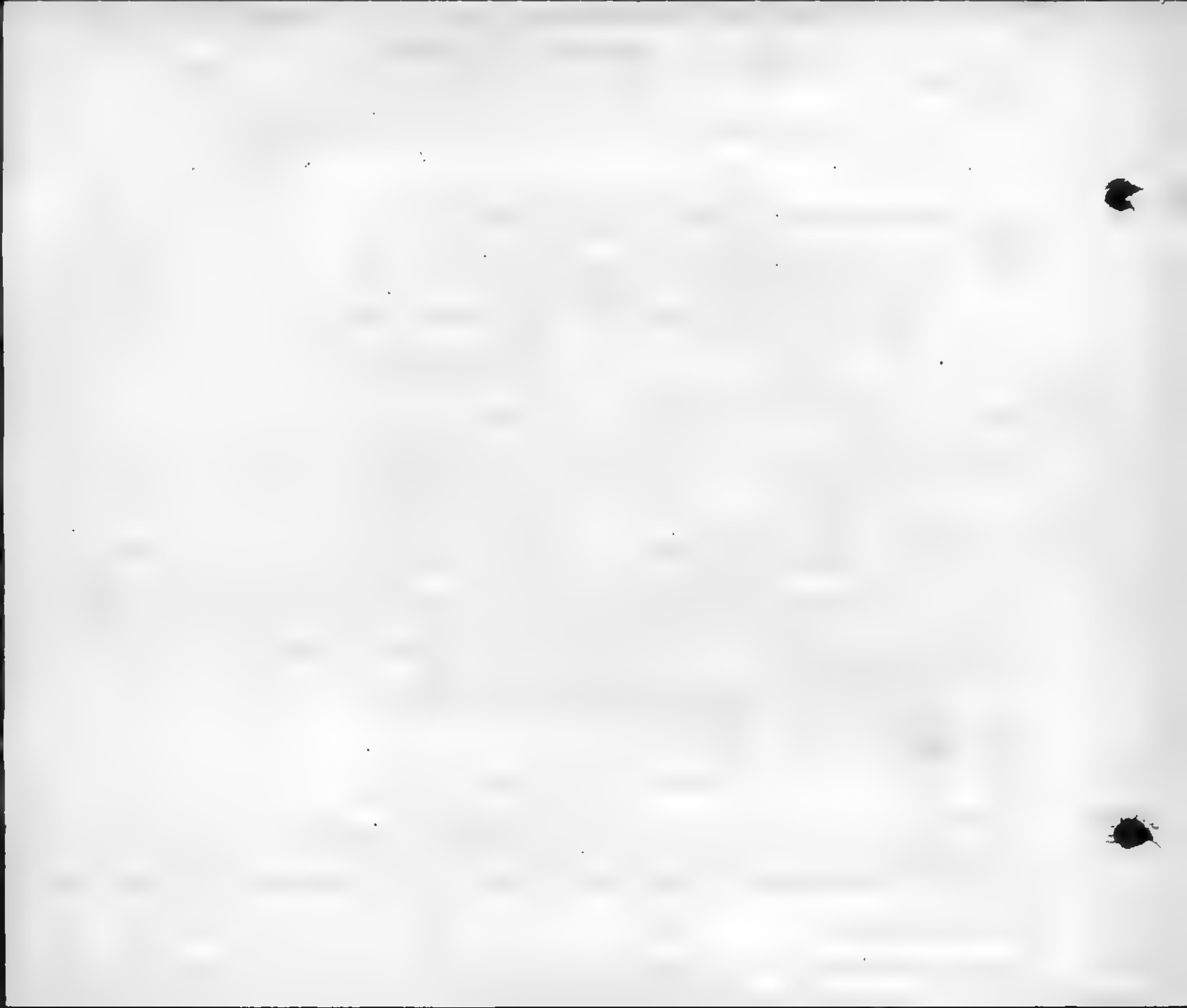
2864

CERTIFICATE OF DEATH

02854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELK LANE - WOODMAN</u>		c. LENGTH OF STAY IN 1b <u>57 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PUBLIC WOODMAN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12200 Rd.</u>				d. STREET ADDRESS <u>12200 Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>LOREN</u> Last <u>SHAW</u>				4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARMY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAID</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE W. SHAW</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE E. SCHWIMM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-36-8395</u>		17. INFORMANT <u>SON - GEORGE SHAW - 6124 DILLON</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>20N-SETTING HEART FAILURE</u> <u>4-0-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10-11-57</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>MAY 25, 1957</u> to <u>MAY 26, 1957</u> that I last saw the deceased alive on <u>MARCH 2, 1957</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Lippert</u> M.D. <u>8204 LIPKITY RD, CATOCTA, MD 3/24/57</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>EDWIN L. LIPPERT M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WILMINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				ADDRESS <u>8728 Liberty Road</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2865

CERTIFICATE OF DEATH

02855

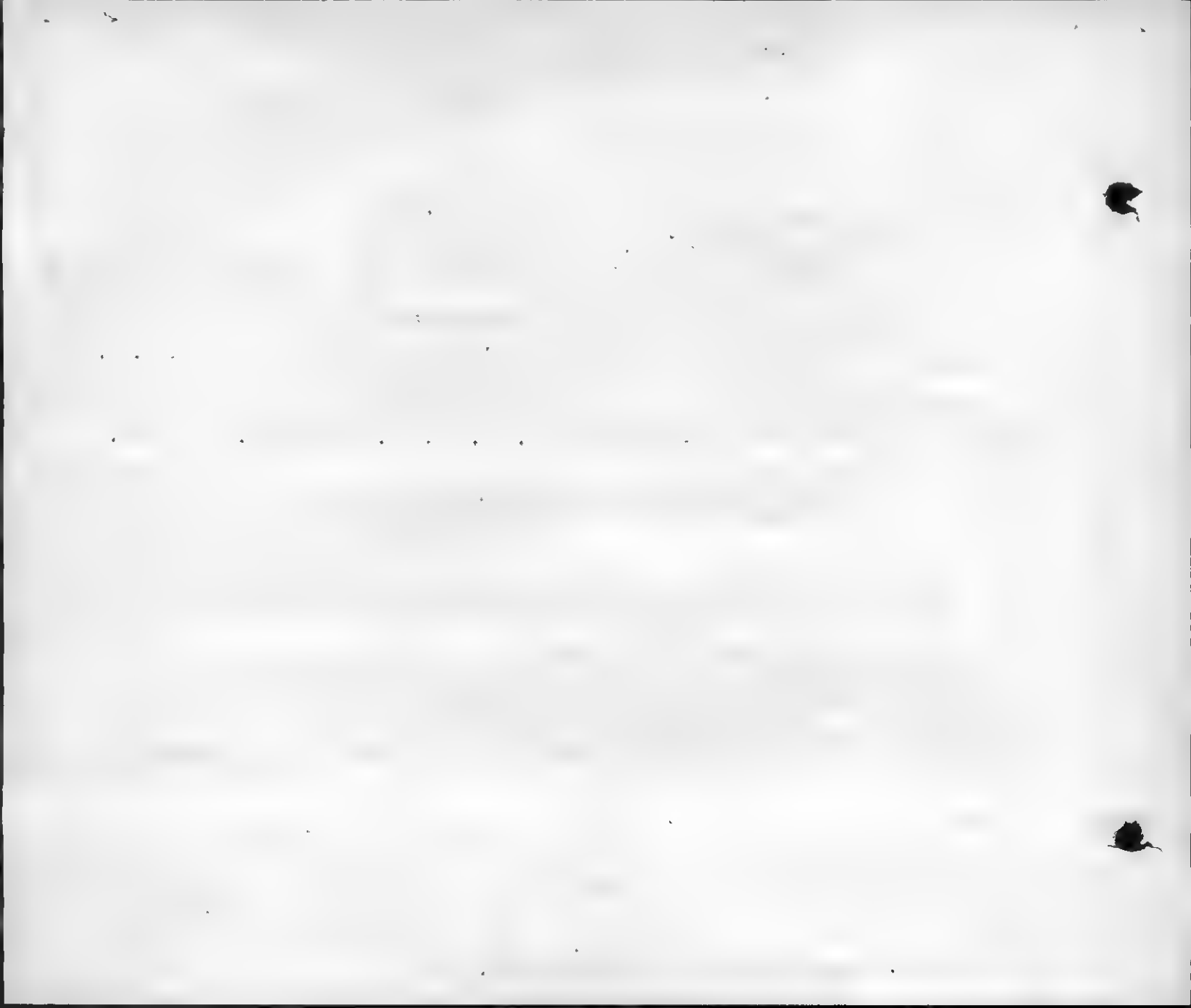
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 105 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 531 N. Belnord Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Served as JOHN First Middle Last SCHAB SCHAP) (Type or print) MICHAEL J. SCHAB		4. DATE OF DEATH Month March Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1900 59 9. AGE (in years last birthday) yrs 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ship Fitter	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Joseph Schap		14. MOTHER'S MAIDEN NAME Catherine Bigda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give date of service) WW I		16. SOCIAL SECURITY NO 213-09-2492	
17. INFORMANT Address Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE ADENOCARCINOMA, RIGHT FLANK, AND RETROPERITONEAL AREA RECURRENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUETO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 5, 1958 to March 20, 1959 and that death occurred at 7:50 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 3/20/59			
ACTUAL SIGNATURE Donald D Mark		PHYSICIAN'S NAME (Type) DONALD D MARK MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-23-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cvach		24a. REC'D BY REGISTRAR MAR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kiana

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2866

CERTIFICATE OF DEATH

02856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 1 1/2 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3044 Moreland Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private 9534 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF home) DECEASED (Type or print) George First Paul Middle Schmidt Last		4. DATE OF DEATH Month 3 Day 22 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Adam Schmidt	
14. MOTHER'S MAIDEN NAME Mary Schowr		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 276-36-4107		17. INFORMANT Address Mrs. Elsa C. Schmidt, 3044 Moreland Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 22 March, 1959 to 19 , that I last saw the deceased alive on 19 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George D. Edwards M. D. March 23, 1959			
ACTUAL SIGNATURE George D. Edwards M. D. March 23, 1959			
PHYSICIAN'S NAME (Type) George D. Edwards, M. D. 9660 Belair Rd. Balto 6, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/59	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Luth Cem.	22d. LOCATION (City town or county) (State) Redland-Derwood, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR MAR 26 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hana

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2867

CERTIFICATE OF DEATH

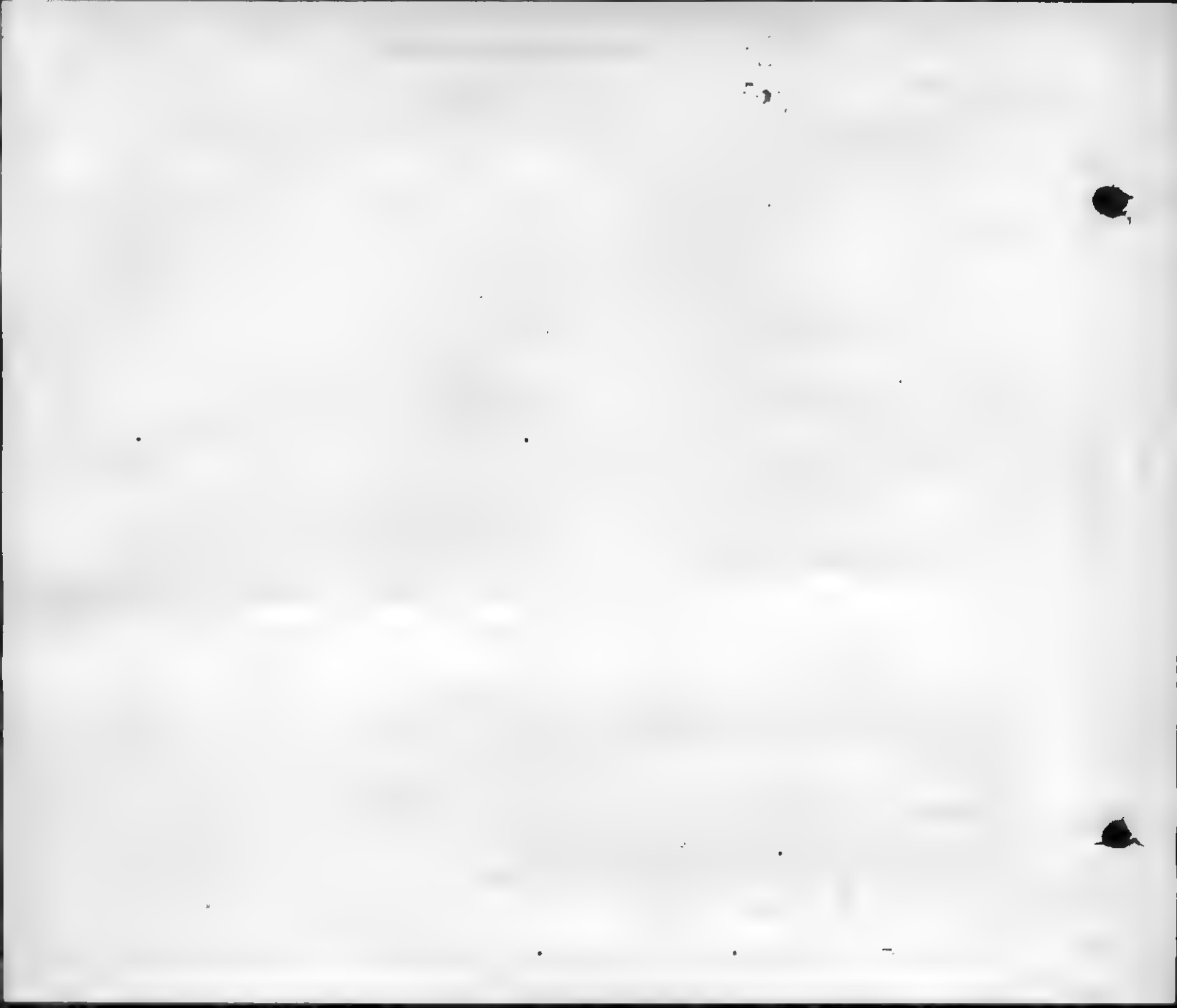
Reg. Dist. No.

02857

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSURANCE 42 Belmore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ELIZABETH SCHEER SCHULTZ		4. DATE OF DEATH March 19, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1872
9. AGE (In years birth day) 86 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Scheer	
14. MOTHER'S MAIDEN NAME Alicia Desmond		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. John McMahon, 42 Belmore Rd. Lutherville Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Advanced atherosclerosis (b) Advanced atherosclerosis (c) Advanced atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH about 3 days about 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 31 , 19 58 to March 19 , 19 59 , that I last saw the deceased alive on March 19 , 19 59 , and that death occurred at 3:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter S. Niblitt		DATE SIGNED 4-4-59	
PHYSICIAN'S NAME (Type) Walter S. Niblitt		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 23/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson		24a. REC'D BY REGISTRAR MAR 23 '59	24b. REGISTRAR'S SIGNATURE Charles E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2868

CERTIFICATE OF DEATH

02858

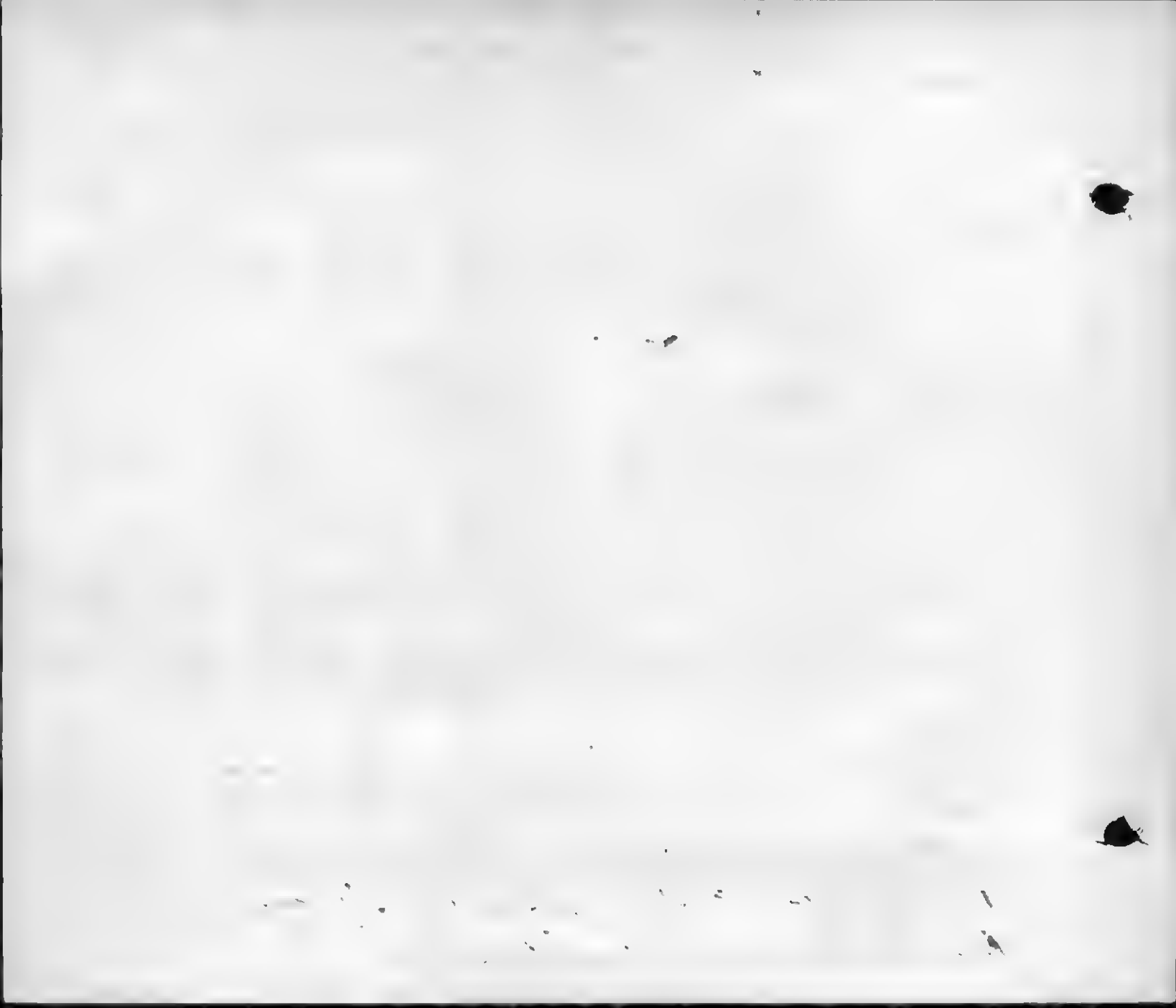
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN IB <u>5yr6mth12dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Bodkin</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 17, 1905</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Ireland</u>							
13. FATHER'S NAME <u>Midnel Bodkin</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Plagarty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb. 6</u> , 19 <u>59</u> , to <u>March 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 17</u> , 19 <u>59</u> , and that death occurred at <u>4:20a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>3-17-59</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/19/59</u>		<u>Garage Cemetery</u>		<u>Garage Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Van der ...</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02859

2869

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex, Maryland	
c. LENGTH OF STAY IN 1b 21yr5mth25dys		d. STREET ADDRESS 717 Myrth Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL			
3. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH Month March Day 23 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 31, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 8 Days 3 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic - cook		10b. KIND OF BUSINESS OR INDUSTRY Worcester, Mass.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown LeMoine		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced atherosclerosis 023X DUE TO Conditions, if any, which gave rise to immediate cause (b) and syphilitic Cardio Vascular (c) Disease DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) On 3-22-59 @ 8:00a.m. patient fell over backwards sustaining abrasion on crown of head	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:00xxx 3-22 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 3-23-59	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-25-59	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Seal of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2870

CERTIFICATE OF DEATH

02860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 35 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berryman's Lane		/d. STREET ADDRESS Berryman's Lane	
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Sentz		4. DATE OF DEATH Month March Day 17 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George S Page		14. MOTHER'S MAIDEN NAME Laura V Welsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215 05 1978B	
17. INFORMANT Newman W Sentz		Address Odenton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 20 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystocele, rectocele, Uterine prolapse			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 8-18-37 19____, to 3-17-59 19____, that I last saw the deceased alive on 3-16-59 19____, and that death occurred at 11 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. D. Caples		ADDRESS (Street, city or town, state) 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		DATE SIGNED 3-18-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 21 1959	
22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman + Sons		24a. REC'D BY REGISTRAR DATE MAR 20 '59	
ADDRESS Reisterstown Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hirsch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural White Hall</u>				c. LENGTH OF STAY IN 1b <u>80 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural White Hall</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u></u> Last <u>Shaeffer</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> , Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1876</u>		9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Shaeffer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Gertrude Shaeffer, White Hall, RD, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>auricular fibrillation and chronic</u> DUE TO (c) <u>myocarditis--decompensation.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10, 1959</u> , to <u>Mar. 11, 1959</u> , that I last saw the deceased alive on <u>March 11, 1959</u> , and that death occurred at <u>11P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman H. Gemmill</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Stewartstown, Pa. Mar. 12, '59</u>			
PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill, M.D.</u>							
22a. BURIAL-CREATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stewartstown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Stewartstown, York Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert W. Fisher</u>				ADDRESS <u>Stewartstown, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2872

CERTIFICATE OF DEATH

02862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemore				c. LENGTH OF STAY IN lb Life				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2806 Delmar Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Joseph Middle R. Last Slachter				4. DATE OF DEATH Month March Day 9 Year 1959				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1908		
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min 00		IF UNDER 24 HRS Hours 15 Min 00				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed				10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Virginia		
						12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Walter Slachter				14. MOTHER'S MAIDEN NAME Martha Hairfield				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-09-6973		17. INFORMANT Mrs. Ruth Slachter Address 2806 Delmar Ave.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung, DUE TO metastatic to skeleton & Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____ INTERVAL BETWEEN ONSET AND DEATH 8								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from March 1, 1959 , to March 9, 1959 , that I last saw the deceased alive on March 8, 1959 , and that death occurred at 10:10 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 914 D Street Baltimore 19, Md. DATE SIGNED _____								
ACTUAL SIGNATURE John V. Conway, M.D.								
PHYSICIAN'S NAME (Type) John V. Conway, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA ADDRESS 7922 Wise Ave. 22m, Md.				24a. REC'D BY REGISTRAR DATE MAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale		



2873

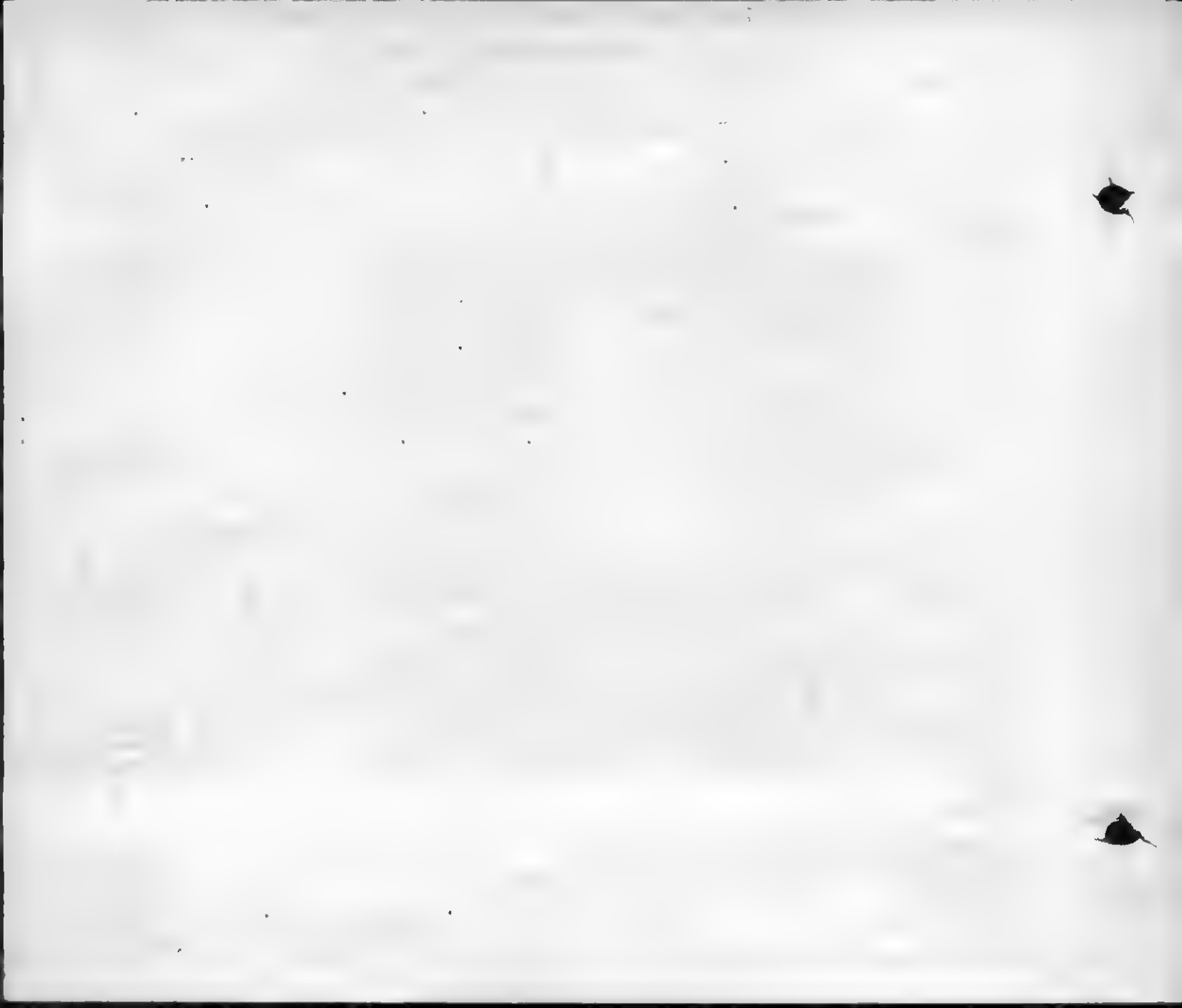
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colonial Gardens (Balto. 28)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colonial Gardens (Balto. 28)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1925 Old Frederick Rd.				d. STREET ADDRESS 1925 Old Frederick Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle PRETTYMAN Last SMACK				4. DATE OF DEATH Month March Day 18 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1874		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joel Smack				14. MOTHER'S MAIDEN NAME Elizabeth C. Dennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address Baltimore 28, Md. Mrs. Kathryn S. VanDyke - 1925 Old Frederick Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 minutes DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 49 , to March 18 , 19 59 , that I last saw the deceased alive on Feb. 19 , 19 59 , and that death occurred at 12:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Schaeffer M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 401 Random Road 3-18-59 Balto. 29 - Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/59		22c. NAME OF CEMETERY OR CREMATORY Bowen Methodist Cem.		22d. LOCATION (City, town, or county) (State) Newark, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Schaeffer ADDRESS 401 Random Road - Balto 17, Md.				24a. RECEIVED BY REGISTRAR DATE MAR 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02864

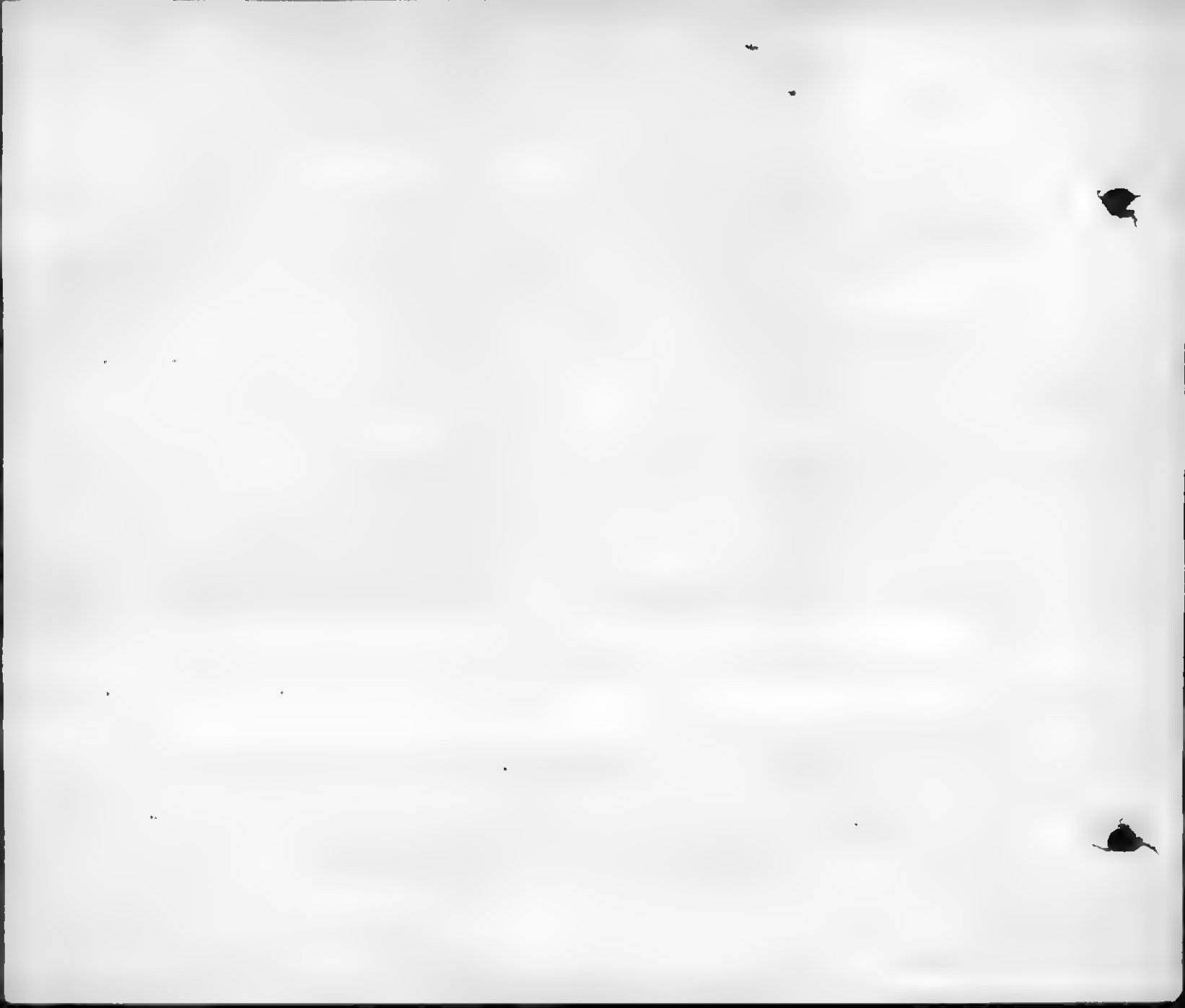
2874

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>1yr 5mth 25dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>Marie</u> <u>Smith</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hessler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Accident fracture Left leg</u> (c) <u>Left leg</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Operative fracture pinned 12-31-58</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>On 12-19-58 at 7:45 p.m. patient was pushed against wall by another patient, with subsequent fall to floor - sustained sub-capital frac. of left femur.</u>		20c. TIME OF INJURY Month, Day, Year <u>12-19 1958</u> Hour <u>7:45</u> <u>PM</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. (City or town) <u>Catonsville, Maryland</u>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		DATE SIGNED <u>3-2-59</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt OLIVER Cem</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS J. KENNY INC.</u>		ADDRESS <u>1600 Hollins</u>	
24a. RECEIVED BY REGISTRAR <u>MAK 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kenny</u>	



2875

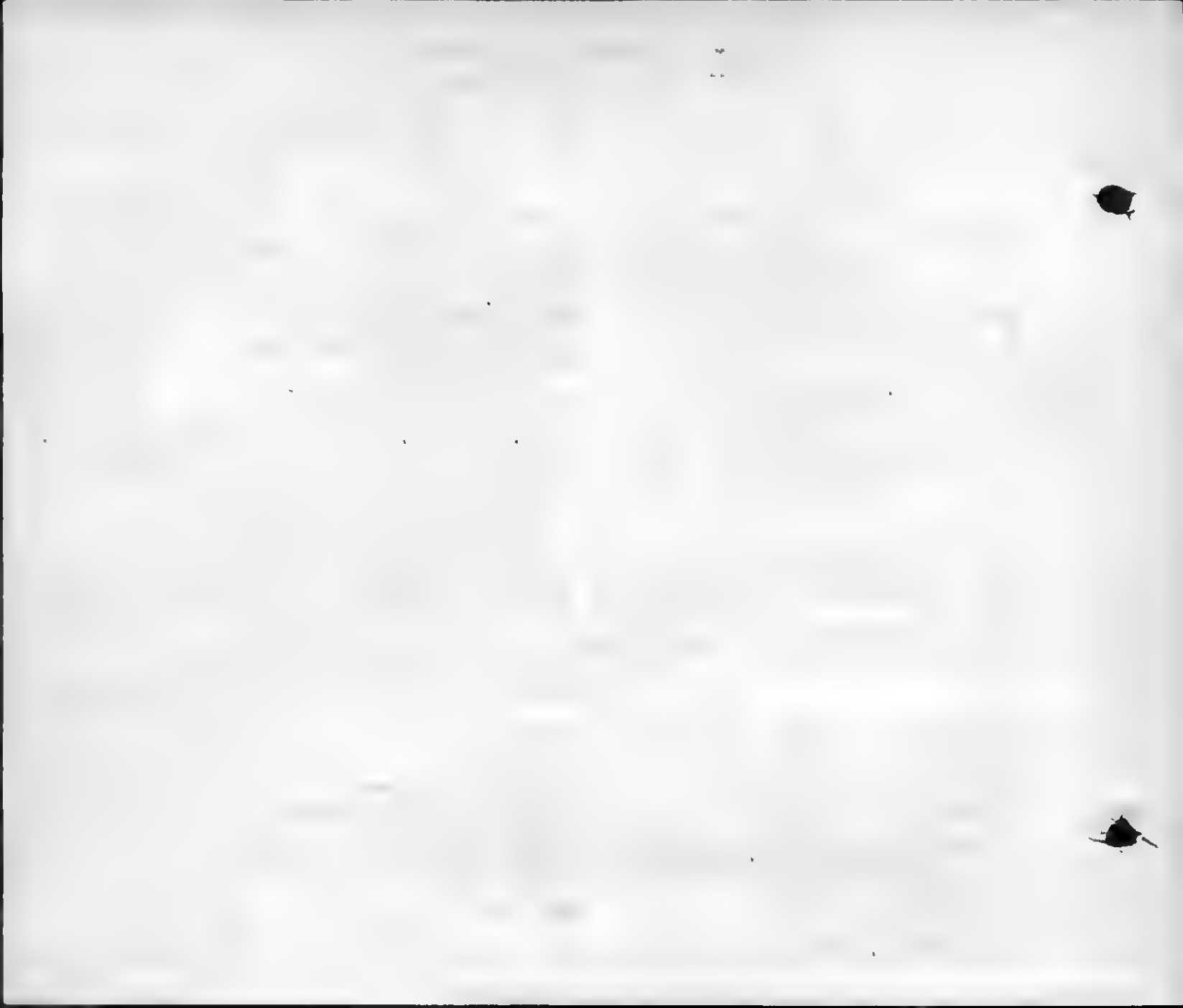
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cromwell Bridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miss Sarah Lee Smith</u>		4. DATE OF DEATH Month Day Year <u>March 24th 1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>John A. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Troy J. Hoover, Box 153 Glen Arm.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arterio Sclerotic Cardio</u> DUE TO (c) <u>Chronic Arterio Sclerotic Hypertension</u> 1952		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>25-Nov</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25-Nov-1952</u> to <u>24-March-1959</u> , that I last saw the deceased alive on <u>23-March-1959</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Wm. Edmonds</u> M.D.		ADDRESS (Street, city or town, state) <u>2746 The Alameda</u> DATE SIGNED <u>3/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Charles Wm. Edmonds</u>		<u>Baltimore, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2876

CERTIFICATE OF DEATH

02866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 45 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lyons Mills Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owings Mills	
3. NAME OF DECEASED (Type or print) First Sophia Middle Smith Last Smith		4. DATE OF DEATH Month 3 Day 3 Year 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARITAL STATUS WIDOWED	8. DATE OF BIRTH 12-18-1862
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Weidman		14. MOTHER'S MAIDEN NAME Roseina Strauss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Harry Weidman		Address Lyons Mill Road Owings Mills	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition, passive Congestion 286.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Femur DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1958 to 2/3/1959 , that I last saw the deceased alive on 3/2/1959 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wm. E. Martin M.D. Randallston PHYSICIAN'S NAME (Type) Wm. E. Martin R Maryland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3. 6. 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Spring Byers		24a. REC'D BY REGISTRAR MAR 9 '59	
ADDRESS 8728 Liberty Road Randallstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 240 4-2-59 et

CERTIFICATE OF DEATH

02867

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wakefield</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Daughter's 2201 Boxmere Road home</i>		d. STREET ADDRESS <i>211 E. 33rd Street</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Susanna Twigg Smith</i>		4. DATE OF DEATH Month Day Year <i>March 25th 19 59</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 11, 1882</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John M. Twigg</i>		14. MOTHER'S MAIDEN NAME <i>Hanna Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <i>Mr. Gerald A. Evans, 2201 Boxmere Road</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas with 157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>generalized peritoneal metastases</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>P DEC 1958</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>DEC 20, 1958</i> to <i>MAR 25, 1959</i> , that I last saw the deceased alive on <i>MAR 25, 1959</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ralph G. Hills</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>18 East Eager Street 3/26/59</i>	
PHYSICIAN'S NAME (Type) <i>Ralph G. Hills</i>		<i>Baltimore, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/28/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cumberland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 30 '59</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Hill</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
6
6
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02868

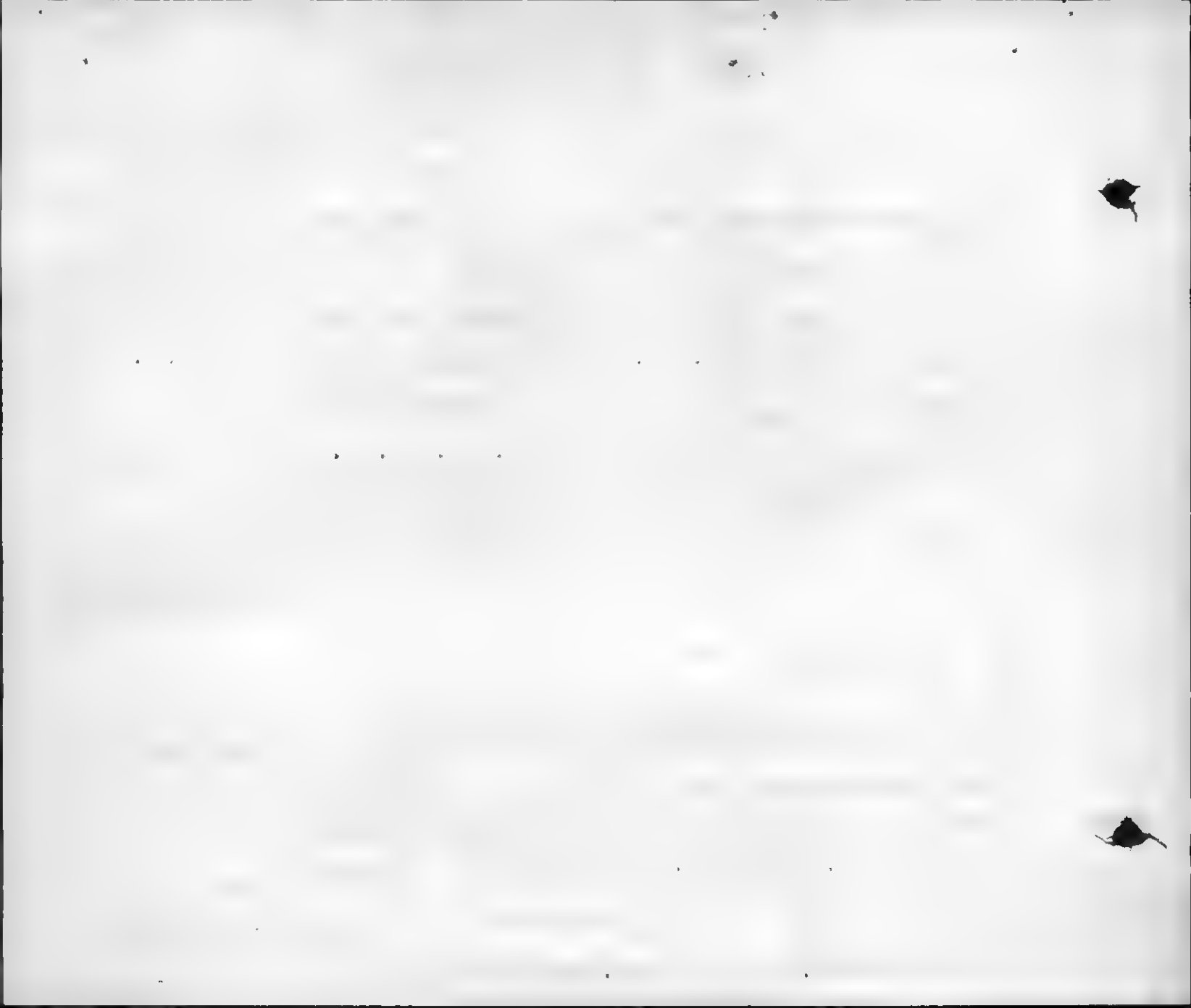
2873

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY ...	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 21 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 51 Fleet Street	
3. NAME OF DECEASED (Type or print) THOMAS Jumbo SMITH		4. DATE OF DEATH March 30 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1881 9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Attendant		10b. KIND OF BUSINESS OR INDUSTRY U.S. N. Academy	
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A	
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Margaret Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) SAW		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA BRONCHOGENIC RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ABSCESSSES MULTIPLE BRAIN DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year VA 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 9, 19 59, to March 30, 19 59 , and that death occurred at 8:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT. HOWARD, MD DATE SIGNED 3/31/59			
ACTUAL SIGNATURE John W. Crawford		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-59	
22c. NAME OF CEMETERY OR CREMATORY Brewer-Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Hicks ADDRESS 45 Northwest St. Annapolis, Md		24a. REC'D BY REGISTRAR APR 3 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 1-1-60-0 4-1-19 et

02869

2879

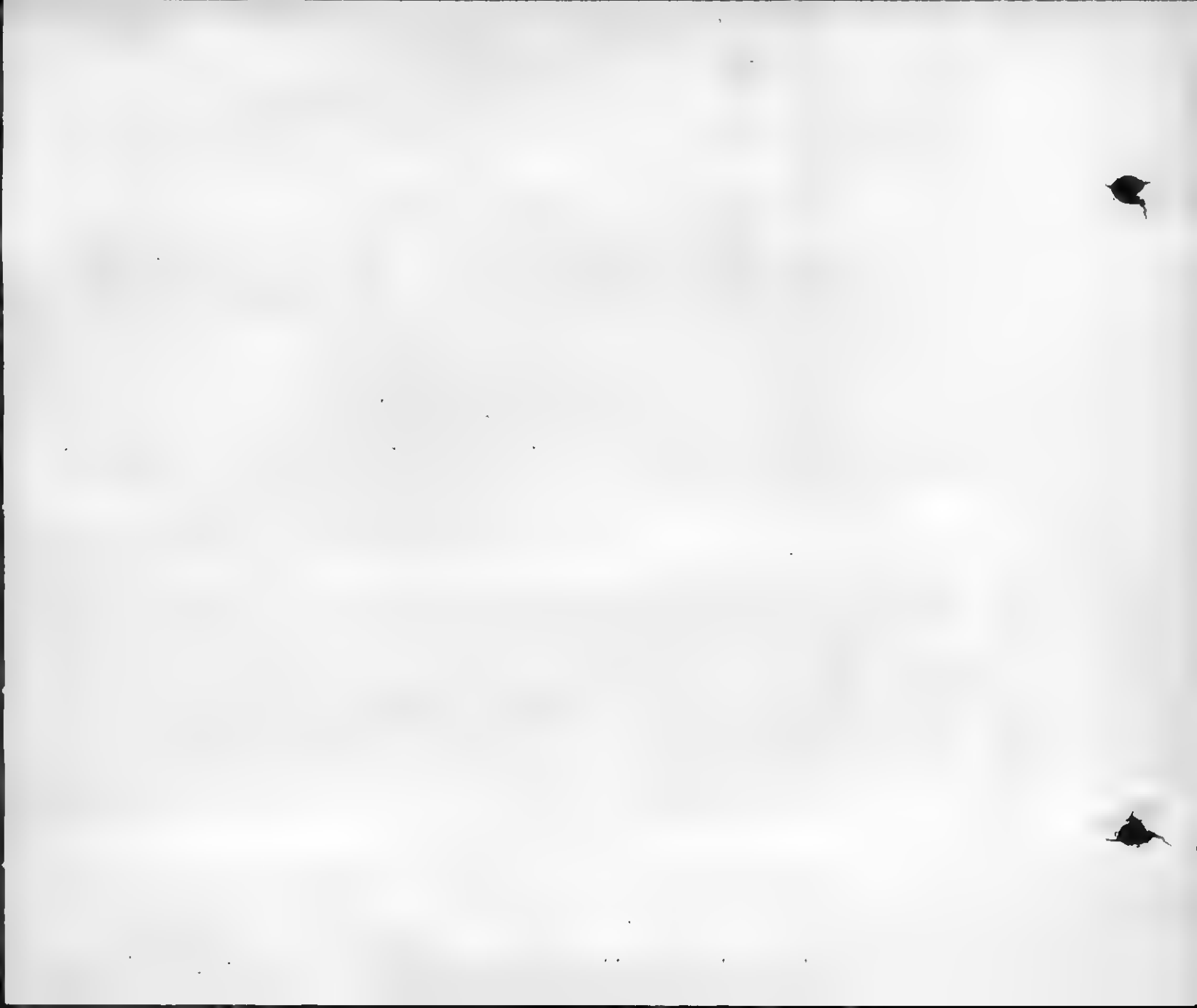
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 Stemmers Run Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REED Middle EDWARD Last SOCCO				4. DATE OF DEATH Month March Day 27 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 26, 1906		9. AGE (In years last birthday) 52 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wheeling, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Socco				14. MOTHER'S MAIDEN NAME Mary E. Platt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 233-03-1230		17. INFORMANT: Sister - Address Mrs. Florence S. Claudy 116 Stemmers Run Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR , 19 58 , to MAR , 19 59 , that I last saw the deceased alive on MAR 25 , 19 59 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Emmett P Davis M.D.				ADDRESS (Street, city or town, state) 5204 BELAIR Rd DATE SIGNED 3/27/59			
PHYSICIAN'S NAME (Type) EMMETT P DAVIS				BALTIMORE 6, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore - Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE STFWART & MOWEN CO. 108 W. North Av., Balot. #1				24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2880

CERTIFICATE OF DEATH

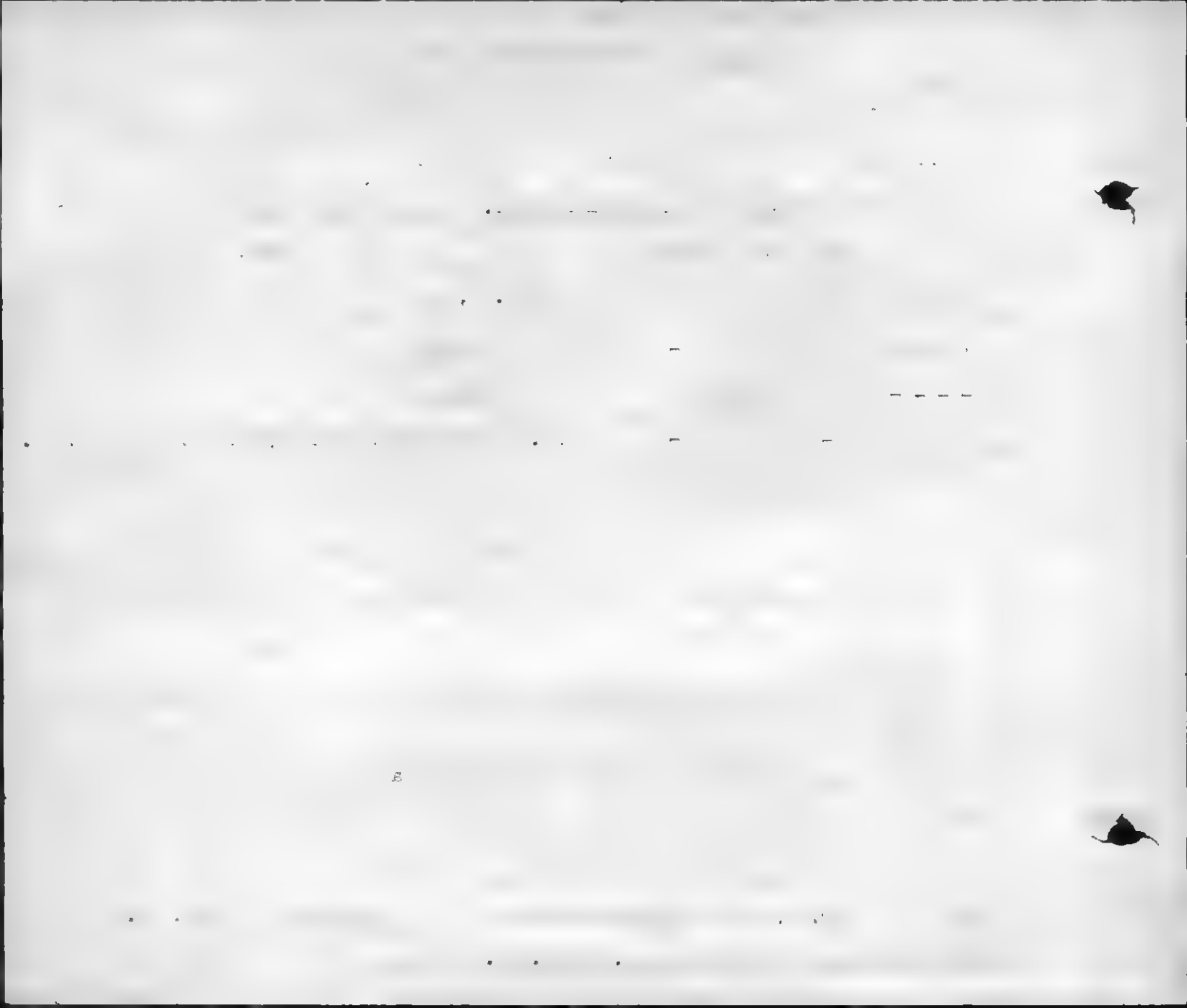
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Forest Haven Nursing Home 315 Ingleside Av.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
3. NAME OF DECEASED (Type or print) Lulie Eliza Somerville				4. DATE OF DEATH Month March Day 3 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1866	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 19 Min.		IF UNDER 24 HRS Months 3 Days 3 Hours 19 Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Downey				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -			
17. INFORMANT Mrs. Dorothy Lewis				Address 702 Bay Street Balto 11, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CORONARY DISEASE DUE TO POSSIBLE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONITIS (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -							
INTERVAL BETWEEN ONSET AND DEATH -							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -	
20f. (City or town) -				20g. (County) -		20h. (State) -	
21. I certify that I attended the deceased from 1/1 19 59 to 3/3 19 59 that I last saw the deceased alive on 3/3 19 59 , and that death occurred at 9 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5800 S. DORCHESTER RD. BALTO. MD. DATE SIGNED 3/4/59 ACTUAL SIGNATURE John H. Shaw M.D. PHYSICIAN'S NAME (Type) John H. Shaw M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) Baltimore County, Md.				22e. (State) -		22f. (County) -	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home 3631 Falls Rd. Balto. Md.				24a. REC'D BY REGISTRAR DATE MAR 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02871

Reg. Dist. No. 18

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write P.O. and give nearest town) <u>Artutur</u>		c. CITY OR TOWN (If outside corporate limits, write P.O. and give nearest town) <u>Artutur</u>	
c. LENGTH OF STAY in 1b <u>17 yrs.</u>		d. STREET ADDRESS <u>1203 Maiden chace lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1203 Maiden chace lane</u>		e. STREET ADDRESS <u>1203 Maiden chace</u>	
3. NAME OF DECEASED (Type or print) <u>WARD H. SPIKER</u>		4. DATE OF DEATH <u>Mar 24 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1904</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>	
11. IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur L Spiker</u>		14. MOTHER'S MAIDEN NAME <u>Annie Ruble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-35-12-1234</u>	
17. INFORMANT <u>Esther H Spiker-Maiden chace</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging with rope in garage from rafters</u> DUE TO (b) <u>suicide</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: <u>garage from rafters</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>suicide</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Hanging from rafters in garage by rope</u>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hanging from rafters in garage by rope</u>		20c. TIME OF INJURY Month, Day, Year <u>6-15 p.m. 3-24-59</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, etc. (City or town) (County) (State) <u>garage at home Artutur Baltimore Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>GEO S.M. KIEFFER</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO S.M. KIEFFER MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 24 1959</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	22d. LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		24a. REC'D BY REGISTRAR <u>Mar 30 '59</u>	
ADDRESS <u>4107 Wilkens Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Hubbard</u>	

THIS MEDICAL EXAMINER'S CERTIFICATE should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

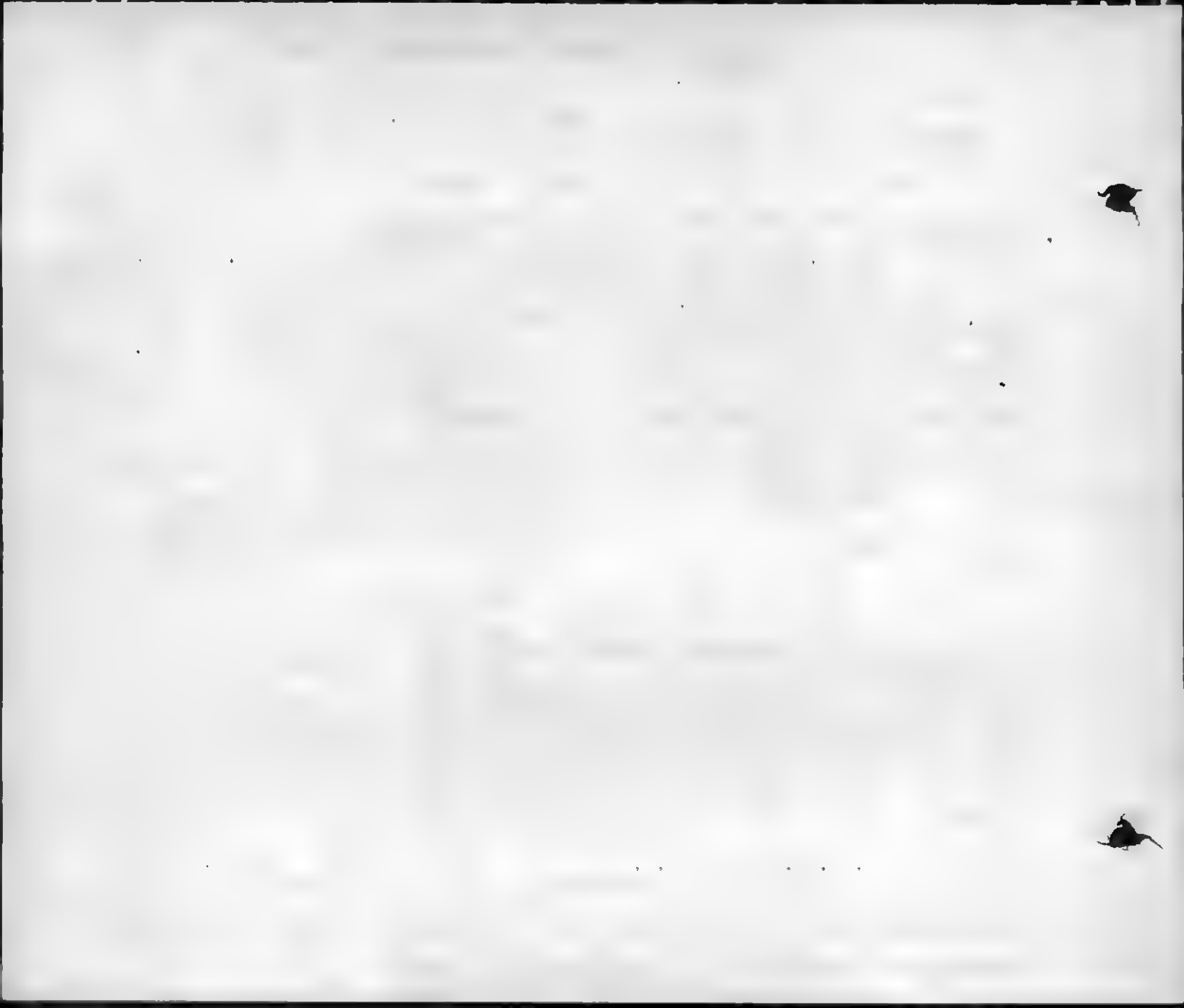
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Highlands</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands</u>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2824 Tennessee Ave.</u>				d. STREET ADDRESS <u>2824 Tennessee Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) <u>Jane S. Squires</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1959</u>														
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1891</u>		9. AGE (in years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>												
13. FATHER'S NAME <u>James Hill</u>				14. MOTHER'S MAIDEN NAME <u>Anna R. Fritzsche</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>218-22-0919</u>		17. INFORMANT <u>Martha Gable 2824 Tennessee Ave</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute Cardiac Failure</u> </td> <td rowspan="3"> INTERVAL BETWEEN ONSET AND DEATH <u> </u> </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>(b)</td> <td><u>Cardio vascular disease</u></td> </tr> <tr> <td>(c)</td> <td><u>Senility . Malnutrition</u></td> </tr> </table> </td> </tr> <tr> <td colspan="2"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> </tr> </table>								PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>(b)</td> <td><u>Cardio vascular disease</u></td> </tr> <tr> <td>(c)</td> <td><u>Senility . Malnutrition</u></td> </tr> </table>		(b)	<u>Cardio vascular disease</u>	(c)	<u>Senility . Malnutrition</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>(b)</td> <td><u>Cardio vascular disease</u></td> </tr> <tr> <td>(c)</td> <td><u>Senility . Malnutrition</u></td> </tr> </table>			(b)	<u>Cardio vascular disease</u>	(c)	<u>Senility . Malnutrition</u>												
(b)	<u>Cardio vascular disease</u>																	
(c)	<u>Senility . Malnutrition</u>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .																		
ACTUAL SIGNATURE <u>Geo. S. N. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>														
EXAMINER'S NAME (Type) <u>Geo. S. N. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>														
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>Feb. 23, 1959</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-31-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Fredricks Rd Baltimore</u>												
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Johnson</u>				ADDRESS <u>2329 Wash Blvd SEB</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>												
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>																		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar/priest to burial, cremation, or removal.



02873

2882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - ROCKDALE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>	
c. LENGTH OF STAY IN 1b <u>2 MONTHS</u>		d. STREET ADDRESS <u>WESTEND AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3508 ROLLING RD, BALTO 7, MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STACK, ESTELLE EDITH</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 25, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NORTH</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Dail</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MRS. AGNES STACK</u>		Address <u>3508 ROLLING RD, BALTO 7.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4:13X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>10 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE MONTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 2, 1959</u> to <u>MARCH 4, 1959</u> , that I last saw the deceased alive on <u>3/2, 1959</u> , and that death occurred at <u>8:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD, BALTO 7, MD</u> DATE SIGNED <u>3/4/59</u>			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.		PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cam</u>		22d. LOCATION (City, town, or county) (State) <u>Hurlock Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u>		ADDRESS <u>Cambridge Maruland</u>	
24a. REC'D BY REGISTRAR <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. France</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2883

CERTIFICATE OF DEATH

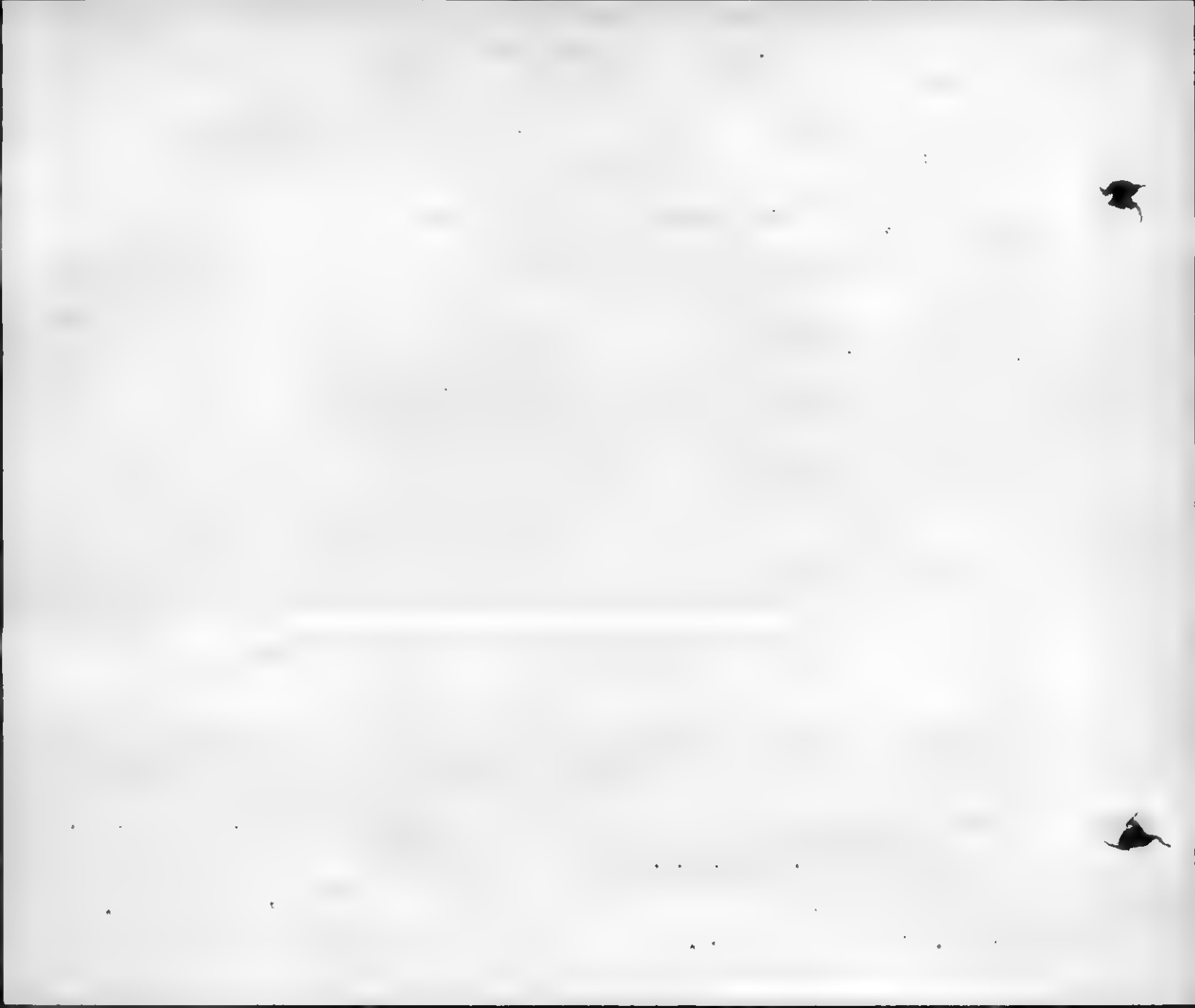
02874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE 109 Monterey Ave b. COUNTY Odenton Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) EVA First Middle Last STEARNS		4. DATE OF DEATH Month March Day 24 Year 1919	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17 1900
9. AGE (in years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Albert Biel		14. MOTHER'S MAIDEN NAME Amanda Bender	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Personal History Address Hospital Records, Eudowood Sanatorium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic carcinoma lung DUE TO (b) Probably from adenocarcinoma kidney DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 17 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1918 to March 24, 1919 , that I last saw the deceased alive on March 24, 1919 , and that death occurred at 1:15 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Milton B. Kress, M.D. Eudowood Sanatorium, Towson 4, Md.			
22a. BURIAL, CREMATION, or other disposition (Specify) cremation			
22b. DATE THEREOF 3/26/59		22c. NAME OF CEMETERY OR CREMATORY Green Mount	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Pl.		24a. REC'D BY REGISTRAR MAR 30 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



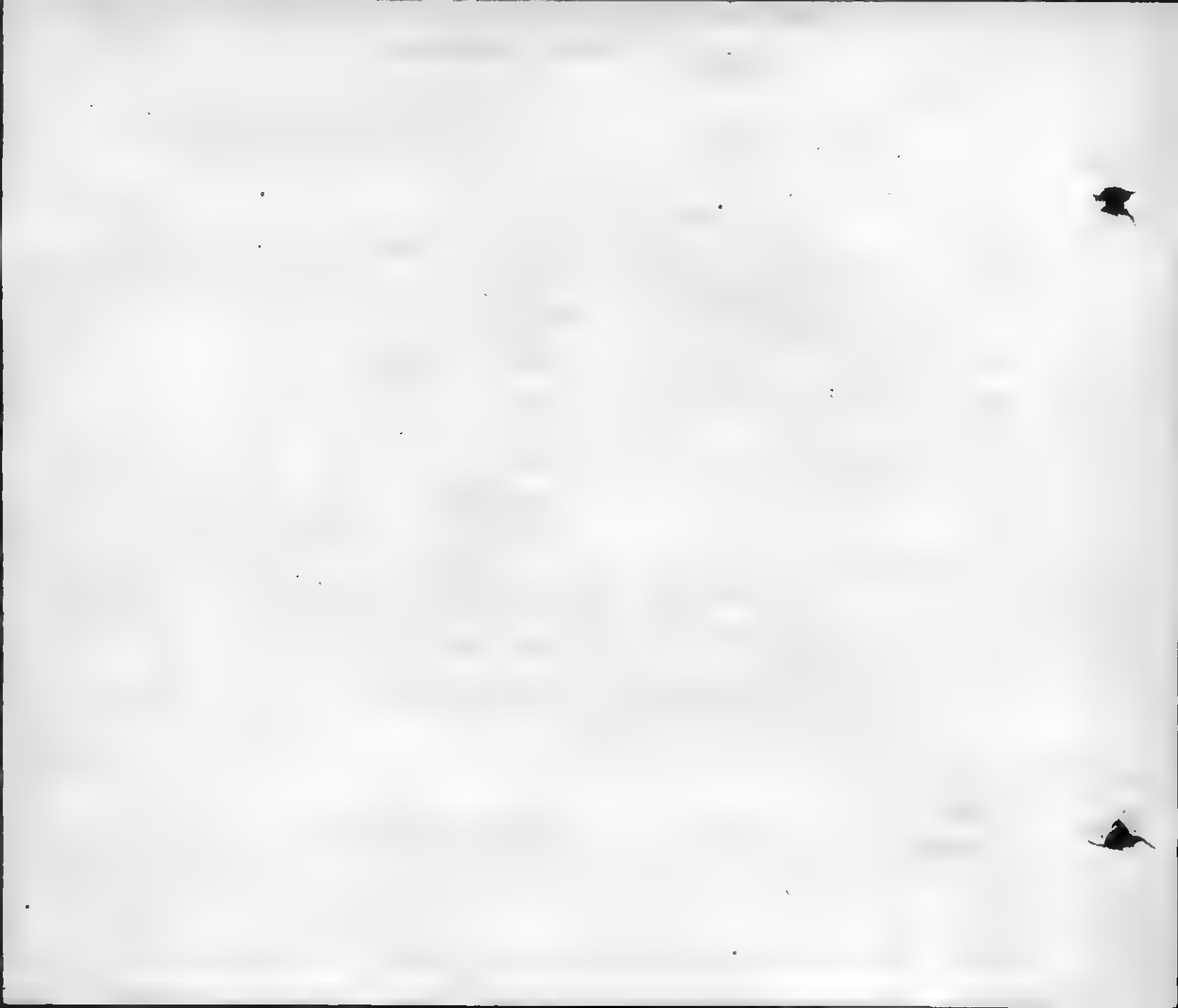
2884
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Padonia Rd.				/d. STREET ADDRESS 101 Padonia Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Franklin Last Stephenson				4. DATE OF DEATH Month March Day 13 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1870	
9. AGE (in years last birthday) yrs 88		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin N, Stephenson				14. MOTHER'S MAIDEN NAME Nancy Jane Schnover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Frederick L. Stephenson Address 3932 Lyndale Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 22 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month March Day 10 Year 1959 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7501 York Rd	
				20f. (City or town) Baltimore		(County) (State)	
21. I certify that I attended the deceased from Oct 1957 to March 13, 1959 , that I last saw the deceased alive on March 10, 1959 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 7501 York Rd Baltimore Md				DATE SIGNED 3/14/59			
ACTUAL SIGNATURE Charles F O'Donnell M.D.							
PHYSICIAN'S NAME (Type) Charles F O'Donnell							
22a. BURIAL, CREMATION, RENOVATION (Specify) Burial		22b. DATE THEREOF 3/16/59		22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gar.		22d. LOCATION (City, town, or county) (State) York Rd Baltimore County.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. ADDRESS 1050 York Rd.				24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

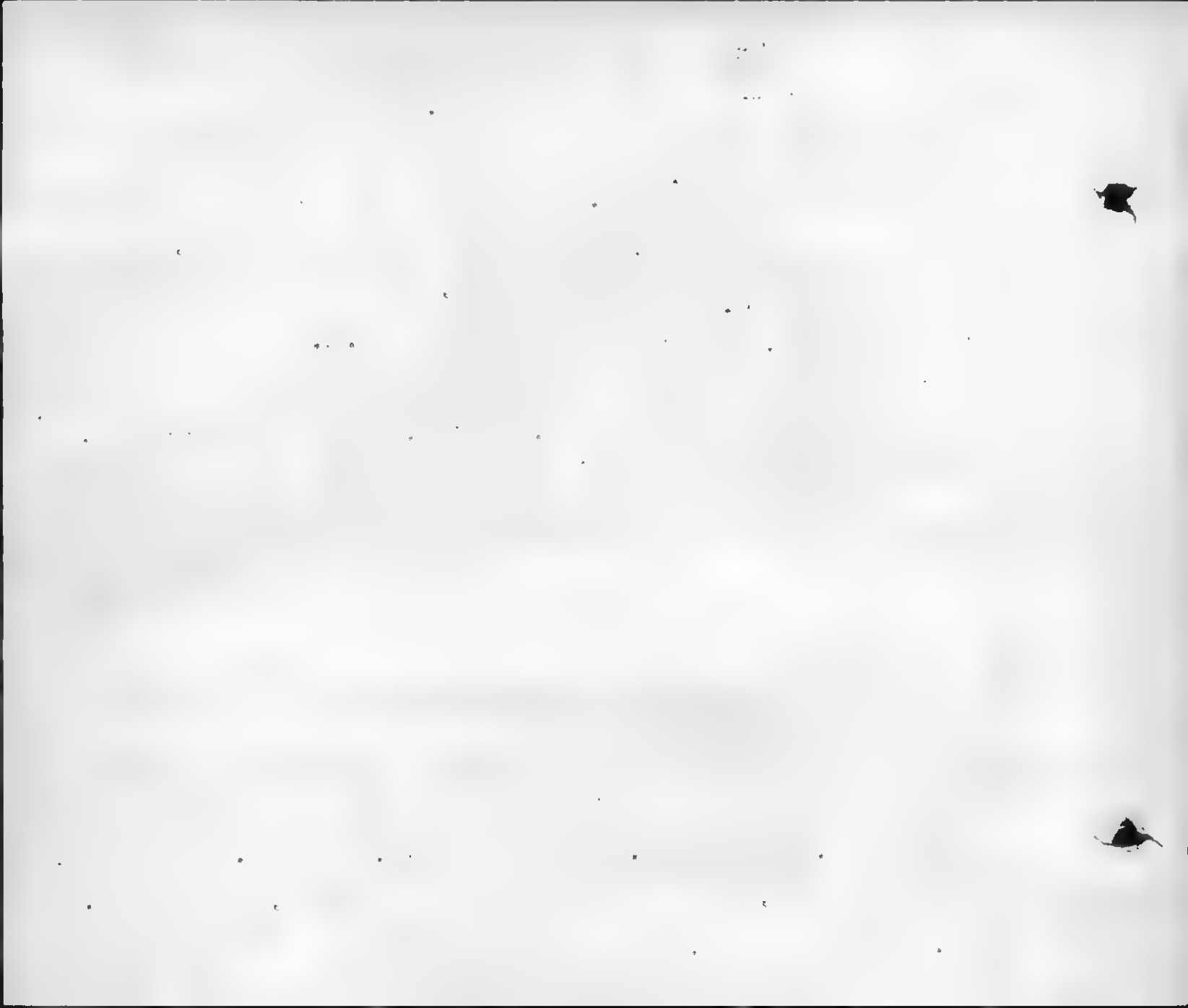
12876

Reg. Dist. No.

2885

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) Towson Convelesent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marguerits Middle Thompson Last Stewart		4. DATE OF DEATH Month March Day 17 Year 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired hostess Dept. Store dining room		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Herbert Thompson		14. MOTHER'S MAIDEN NAME Cecelia Covington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Cecelia S. Chandler		Address 120 Greenbrier Rd. Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Phlebotomy 11, 2020 66 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 1 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis & cardiac atrophy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 to July 1959 , that I last saw the deceased alive on July 19 59 , and that death occurred at 10 30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 N. Charles St. DATE SIGNED John B. DeHoff			
ACTUAL SIGNATURE John B. DeHoff M.D.		M.D. John B. DeHoff	
PHYSICIAN'S NAME (Type) John B. DeHoff		ADDRESS 220 N. Charles St.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Pl.	
24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



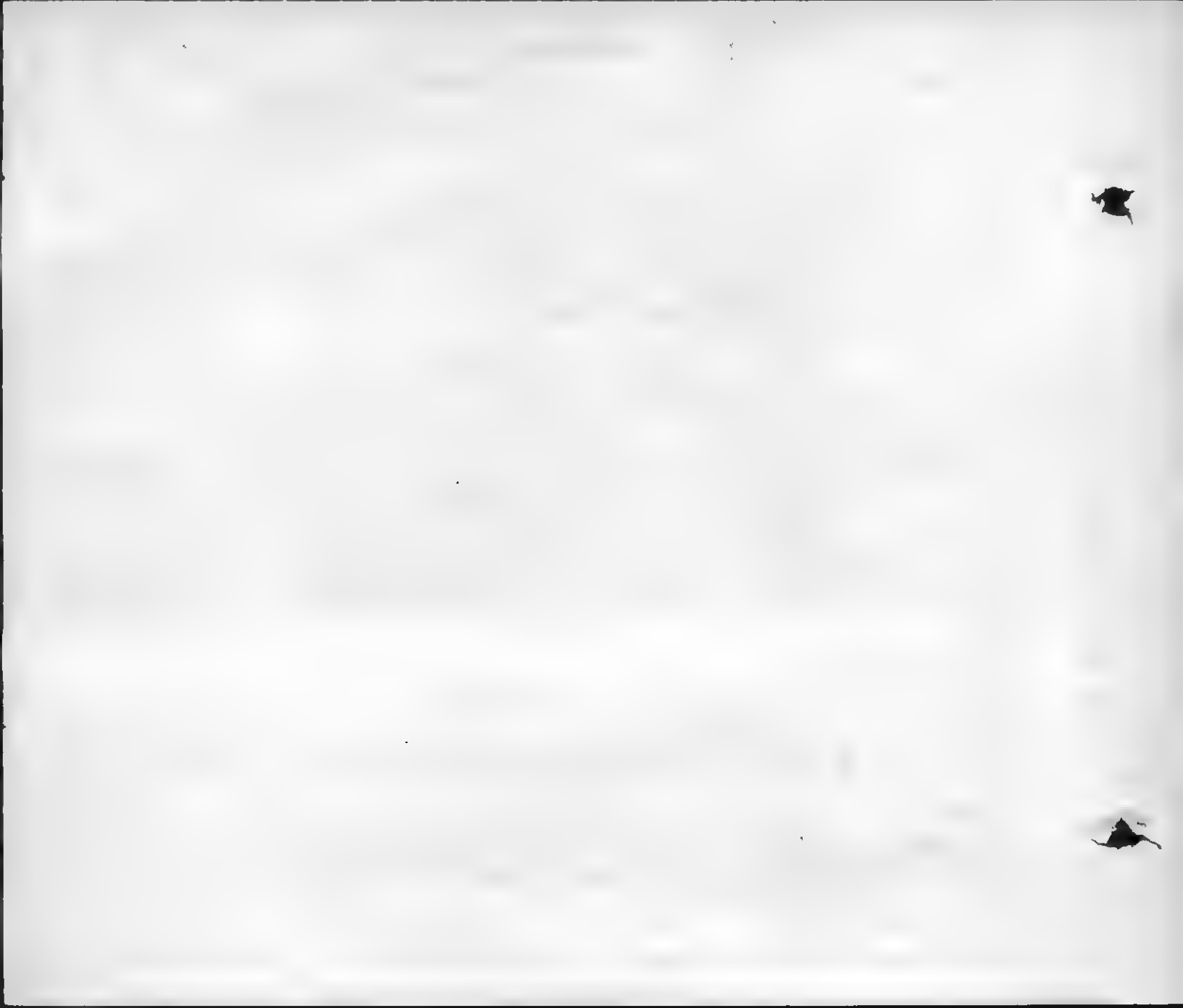
2886

CERTIFICATE OF DEATH

Reg. Dist. No. 02877

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd</u>		d. STREET ADDRESS <u>York Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lida K. Stocksdale</u>		4. DATE OF DEATH Month Day Year <u>March 16 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1892</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cunhame</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm F. Kauffman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Carroll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Otis Stocksdale, Parkton, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> <u>153.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 10</u> , 19 <u>57</u> , to <u>Mar. 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar. 10</u> , 19 <u>59</u> , and that death occurred at <u>7:55 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>3/11/59</u>			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u> <u>Parkton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 12 1959</u>	<u>Maryland Line Cem.</u>	<u>Maryland Line Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob H. Hinton, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	
DATE <u>MAR 12 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2887

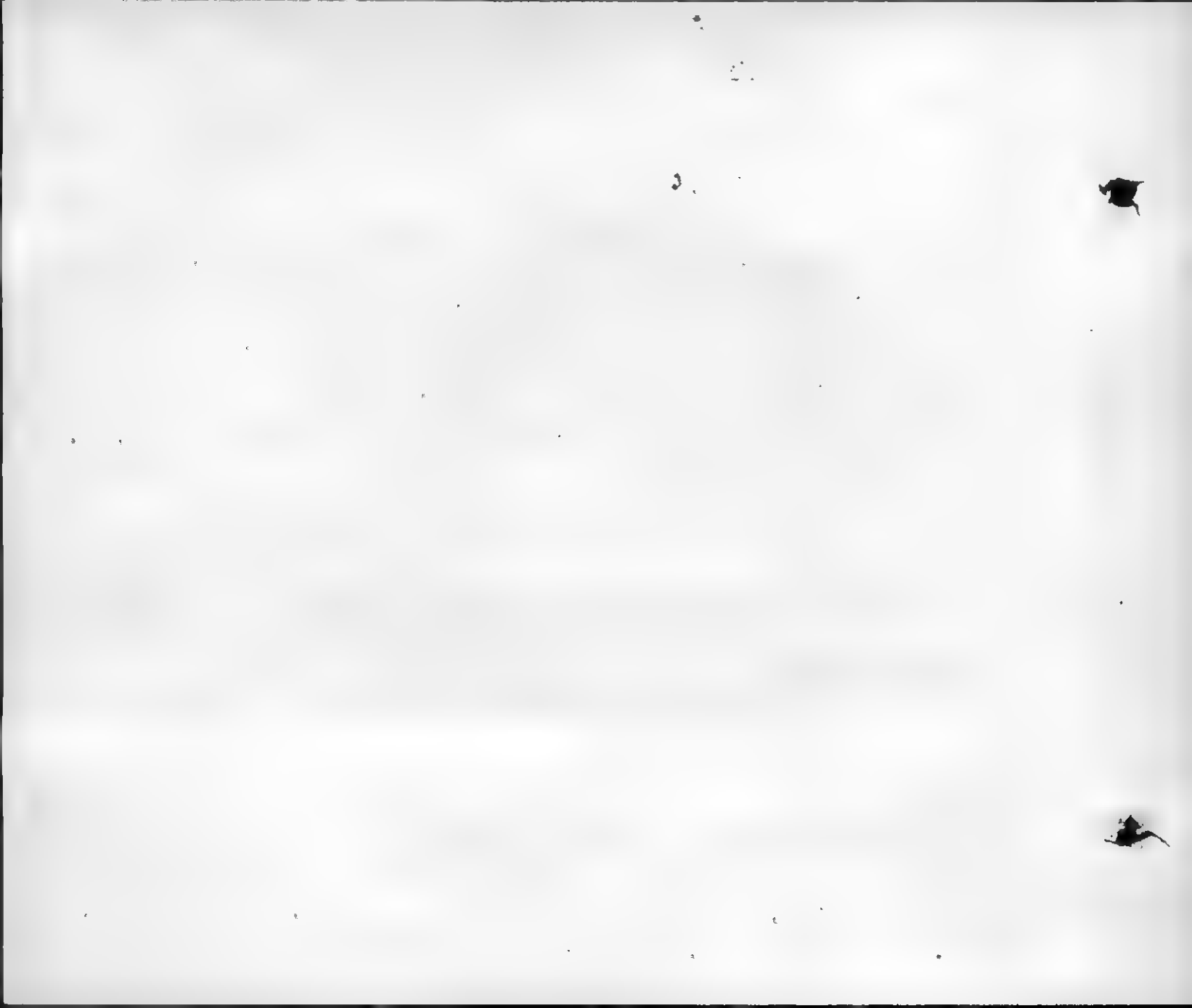
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home of Maryland		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Julia D. Stokes		4. DATE OF DEATH Month March Day 31 Year 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1878
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME James Franklin Devoe		14. MOTHER'S MAIDEN NAME Eliza G. Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records of Presbyterian Home		Address Towson 4, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO A coronary occlusion with myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. [City or town] (County) (State)		20g. [City or town] (County) (State)	
21. I certify that I attended the deceased from JAN 1 , 1958, to MAR 31 , 1959, that I last saw the deceased alive on MARCH 31 , 1959, and that death occurred at 3:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 7215 York Rd DATE SIGNED APR 12 1959			
ACTUAL SIGNATURE S. J. Venable Jr		M.D. APR 12 1959	
PHYSICIAN'S NAME (Type) S. J. VENABLE JR		BIRTH Dec 19 1878	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 3, 1959	22c. NAME OF CEMETERY OR CREMATORY Bethal	22d. LOCATION (City, town, or county) (State) Madonna, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Place	
24a. REC'D BY REGISTRAR APR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2888

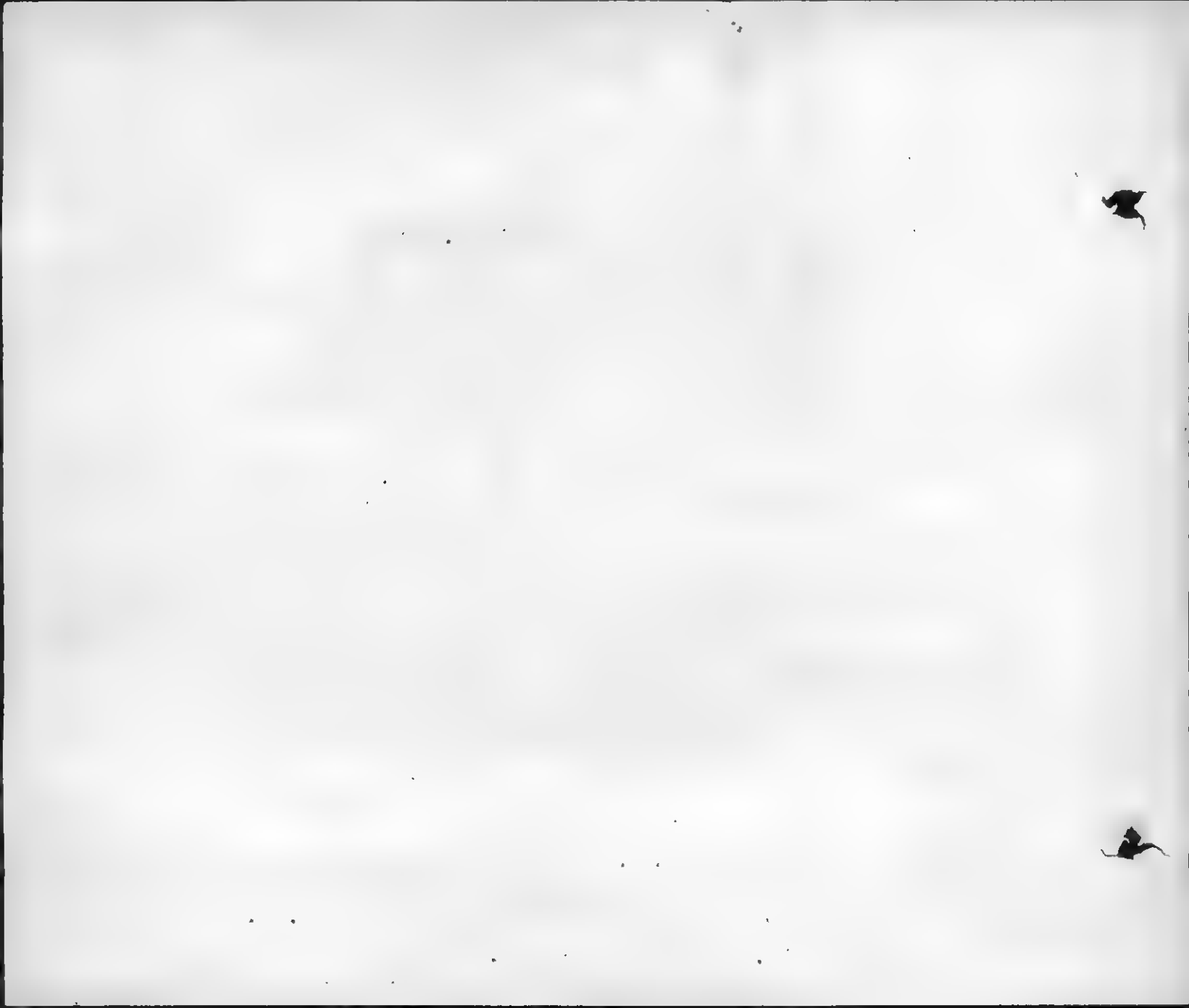
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>V</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Spring Grove St. Hosp</u>		e. STREET ADDRESS <u>526 Allendale St</u>	
3. NAME OF DECEASED (Type or print) <u>Ann Margaret Stone</u> First Middle or <u>Annie M. Stone</u> DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1959</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Mack</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Fuller</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Joseph Mack-Heath</u> Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-12</u> , 19 <u>59</u> , to <u>3-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-26</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachsler</u> M D		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>3-27-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		Catonsville 28, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Balto.Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Dir. 4101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinnel</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2889

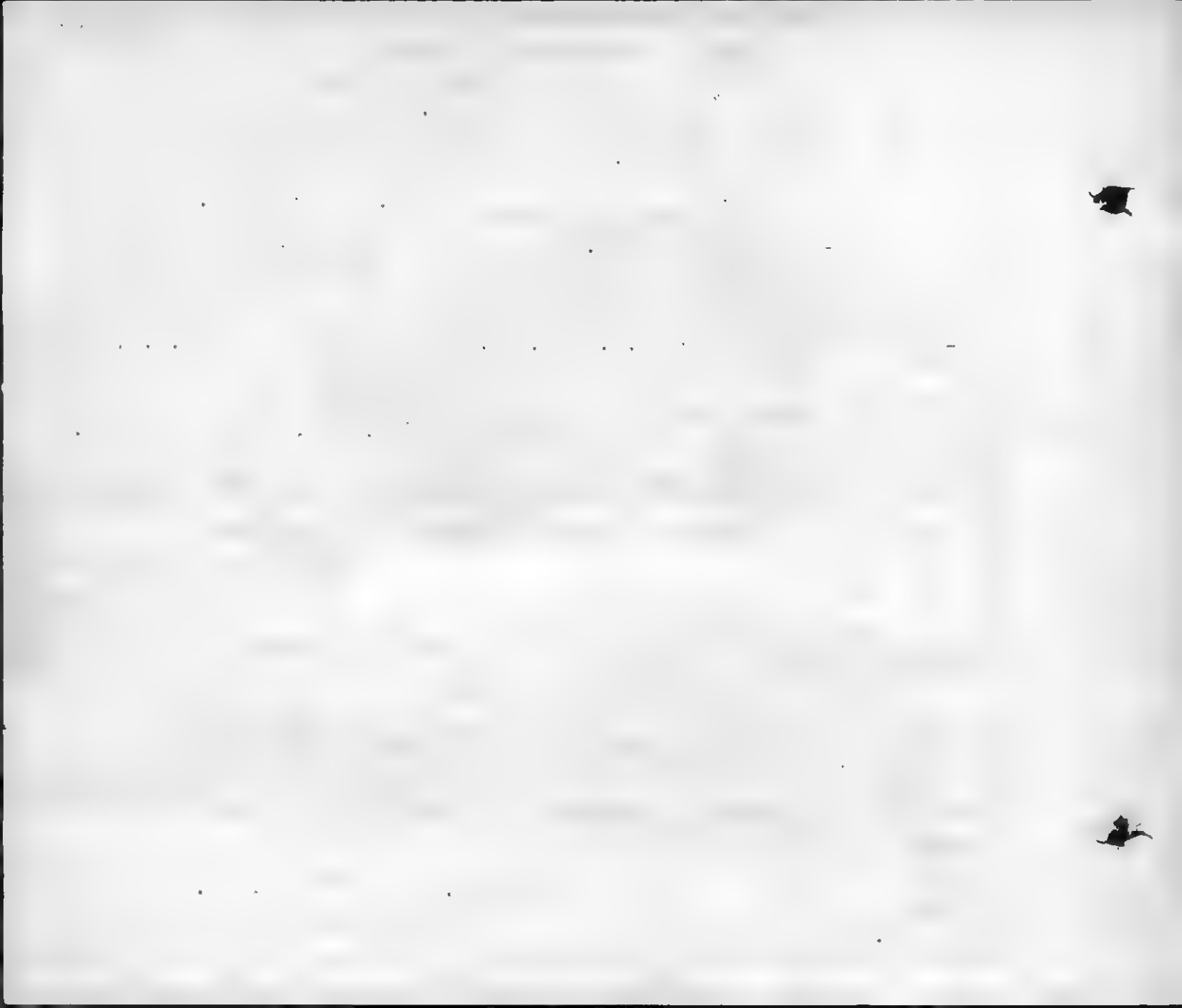
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Res'dence before admission) o STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home				d. STREET ADDRESS 809 N. Luzerne Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last (James-Jerry) Jaroslav A. Svejda				4. DATE OF DEATH Month March Day 10 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1877	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Mechanical Engineer -U.S.Govt.		10b. KIND OF BUSINESS OR INDUSTRY -U.S.Govt.		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Address Norbert Svejda, son, 5919 Eurith Ave. 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Cerebro-Vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic Cardio Vascular Disease DUE TO (c) 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 19 57 , to March 9 19 59 , that I last saw the deceased alive on March 9 19 59 , and that death occurred at 6 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Baumgardner M.D.				ADDRESS (Street, city or town, state) Baltimore Md		DATE SIGNED 3/11/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/59		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 3331 Brehms Lane				24a. REGISTRY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE John A. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2890

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Res dence before adm ssion) a STATE Maryland		b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 99 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		(2)	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d STREET ADDRESS 646 West Saratoga Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) LA VAUGHN		First Middle Last — — —		4. DATE OF DEATH March 10 1959		Day Year	
5. SEX Male		6. COLOR OR RACE Colored		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH April 22, 1914	
9 AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper - Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucker		11. BIRTHPLACE (State or foreign country) Anniston, Alabama		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Allen Swanson				14. MOTHER'S MAIDEN NAME Mary Blackman			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16 SOCIAL SECURITY NO WW II 217-07-2303		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA, RIGHT PYRIFORM FOSSA; TUMOR METASTASES TO CERVICAL LYMPH NODES AND RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1, 1958, to March 10, 1959, and that death occurred on March 10, 1959, at 4:10 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FT. HOWARD, MD. 3/11/59 PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D. VAH, FORT HOWARD, MARYLAND 3/11/59							
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 3/13/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, Baltimore 17, Md.				24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2895

CERTIFICATE OF DEATH

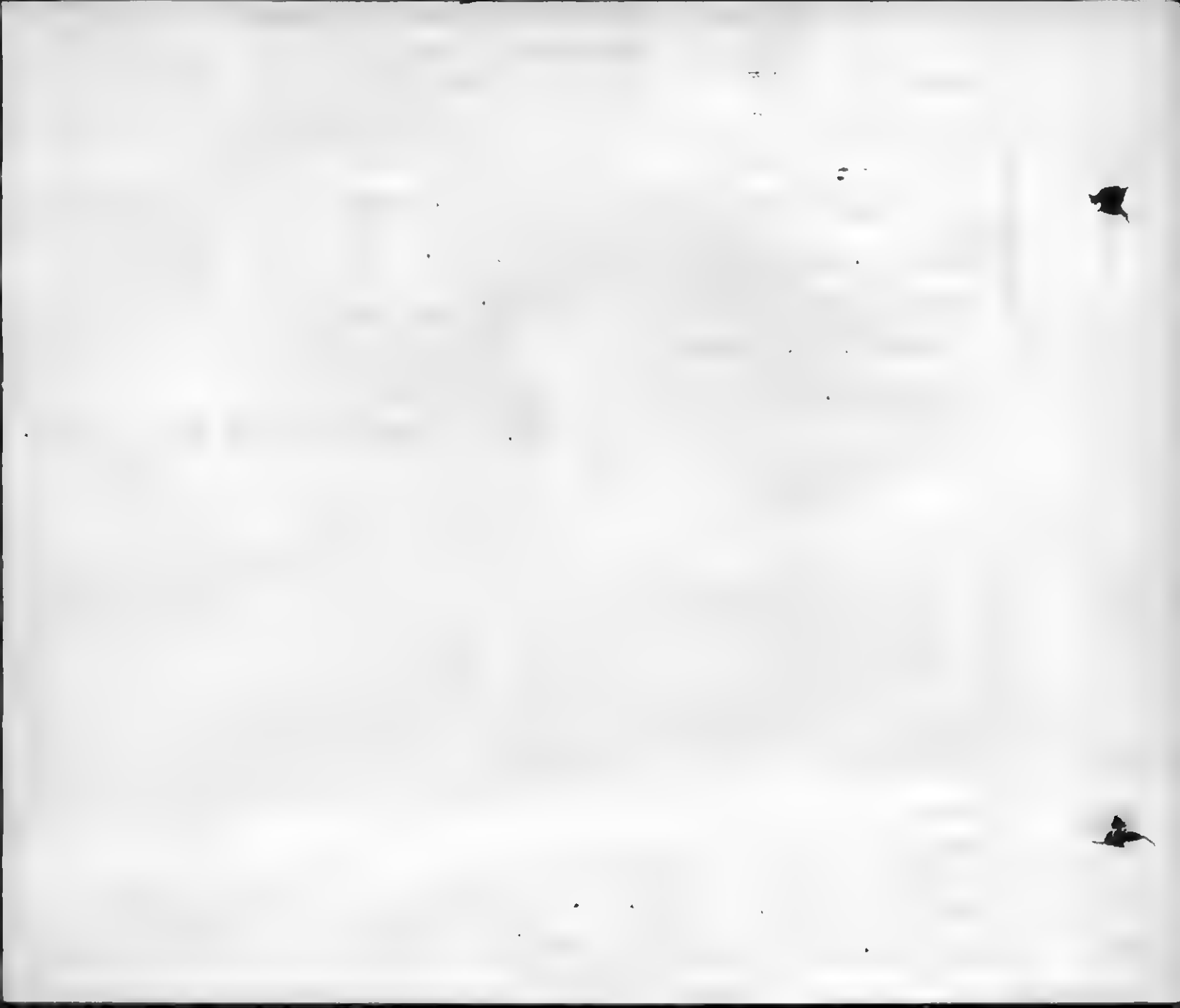
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1705 Aberdeen Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
3. NAME OF DECEASED (Type or print) Mr. Christopher West Tabb, Sr.		4. DATE OF DEATH March 6th 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 3, 1879
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Clerk	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William K. Tabb		14. MOTHER'S MAIDEN NAME Martha Jane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 1705 Aberdeen Road	
17. INFORMANT Mrs. Ella Mae Tabb		Address 1705 Aberdeen Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerosis & Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dissecting Aortic Aneurysm (c) Dissecting Aortic Aneurysm			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Baltimore, Maryland
21. I certify that I attended the deceased from March 12, 1959 to March 12, 1959 that I last saw the deceased alive on March 12, 1959 and that death occurred at Home M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3033 W. D. 17th A DATE SIGNED March 12, 1959			
ACTUAL SIGNATURE M. Paul Byerly		M.D. Baltimore, Md	
PHYSICIAN'S NAME (Type) M. Paul Byerly			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR March 10, 1959	
ADDRESS 5305 Harford Road #14		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02883

2892

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lutherville</u>			
c. LENGTH OF STAY IN 1b <u>50 years</u>				d. STREET ADDRESS <u>1436 Beloma Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1436 Beloma Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>Boyd</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Chase City, Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>unk.</u>				14. MOTHER'S MAIDEN NAME <u>unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or only/own) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Zella Johnson</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>IX</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>same years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 15, 1959</u> , to <u>March 17, 1959</u> , that I last saw the deceased alive on <u>March 15, 1959</u> , and that death occurred at <u>4:20 A.M.</u> , from the causes and on the date stated above.							
ACTING PHYSICIAN'S SIGNATURE <u>Walter T. Kees</u>				ADDRESS (Street, city or town, state) <u>Cockeysville, Md</u>			
DATE SIGNED <u>March 16, 1959</u>							
NAME (Type) <u>Walter T. Kees</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 19, 1959</u>		<u>Pleasant Rest</u>		<u>Towson, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter T. Kees</u>				ADDRESS <u>1431 W. 11th St. Baltimore</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u>MAR 17 '59</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Form 240 3-30-54 et

CERTIFICATE OF DEATH

02884

Reg. Dist. No.

2893

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN IB 16 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home - Painters Mill Road				/ d. STREET ADDRESS Painters Mill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILBERT DORSEY Middle TAYLOR Last				4. DATE OF DEATH Month 3 Day 26 Year 19 59			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6. 1878		9. AGE (In years lost birthday) yrs 80	IF UNDER 1 YEAR Months Days Hours M n	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dorsey Taylor			14. MOTHER'S MAIDEN NAME Lisa Bell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT Son-in-law Address Mill			
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Granuloma Fungoides DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild virus infection						INTERVAL BETWEEN ONSET AND DEATH 8 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 May 19 58 , to 26 March 19 59 , that I last saw the deceased alive on 25 March 19 59 , and that death occurred at 9:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 802 Cathedral Street DATE SIGNED							
ACTUAL SIGNATURE J. Douglas Lockard M.D.				ADDRESS (Street, city or town, state) 802 Cathedral Street			
PHYSICIAN'S NAME (Type) J. Douglas Lockard M.D.				BALTIMORE 1, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 28, 1959		22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		22d. LOCATION (City, town, or county) (State) Rayville, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE STEWART & MOWEN COMPANY - 108 W. North Av.-				ADDRESS Balto.		24a. REC'D BY REGISTRAR MAR 30 '59	
				24b. REGISTRAR'S SIGNATURE W. S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Filed 12-4-59 et

CERTIFICATE OF DEATH

02885

Reg. Dist No.

2894

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give address of residence) <u>1300 Glade Ave</u>		d. STREET ADDRESS <u>4300 Liberty Heights Ave</u>	
3 NAME OF <u>Jennie</u> First <u>J Thaler</u> Middle <u>J</u> Last <u>Thaler</u>		4. DATE OF DEATH <u>5-31-1959</u>	
5. SEX <u>Female</u>	6. CO. OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
13 FATHER'S NAME <u>Joseph Schwaber</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>INFORMANT</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 170X DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of left breast.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 Mo.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 7</u> , 1956, to <u>3/31</u> , 1959, that I last saw the deceased alive on <u>3/31</u> , 1959, and that death occurred at <u>11:29</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Tingle grounds APT. 4/1/59</u>			
ACTUAL SIGNATURE <u>A. A. Silver</u>		M.D. <u>Tingle grounds APT. 4/1/59</u>	
PHYSICIAN'S NAME (Type) <u>A. A. SILVER. M.D.</u>		<u>Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u> ADDRESS <u>2100 Eutan Place</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death may be referred to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02886

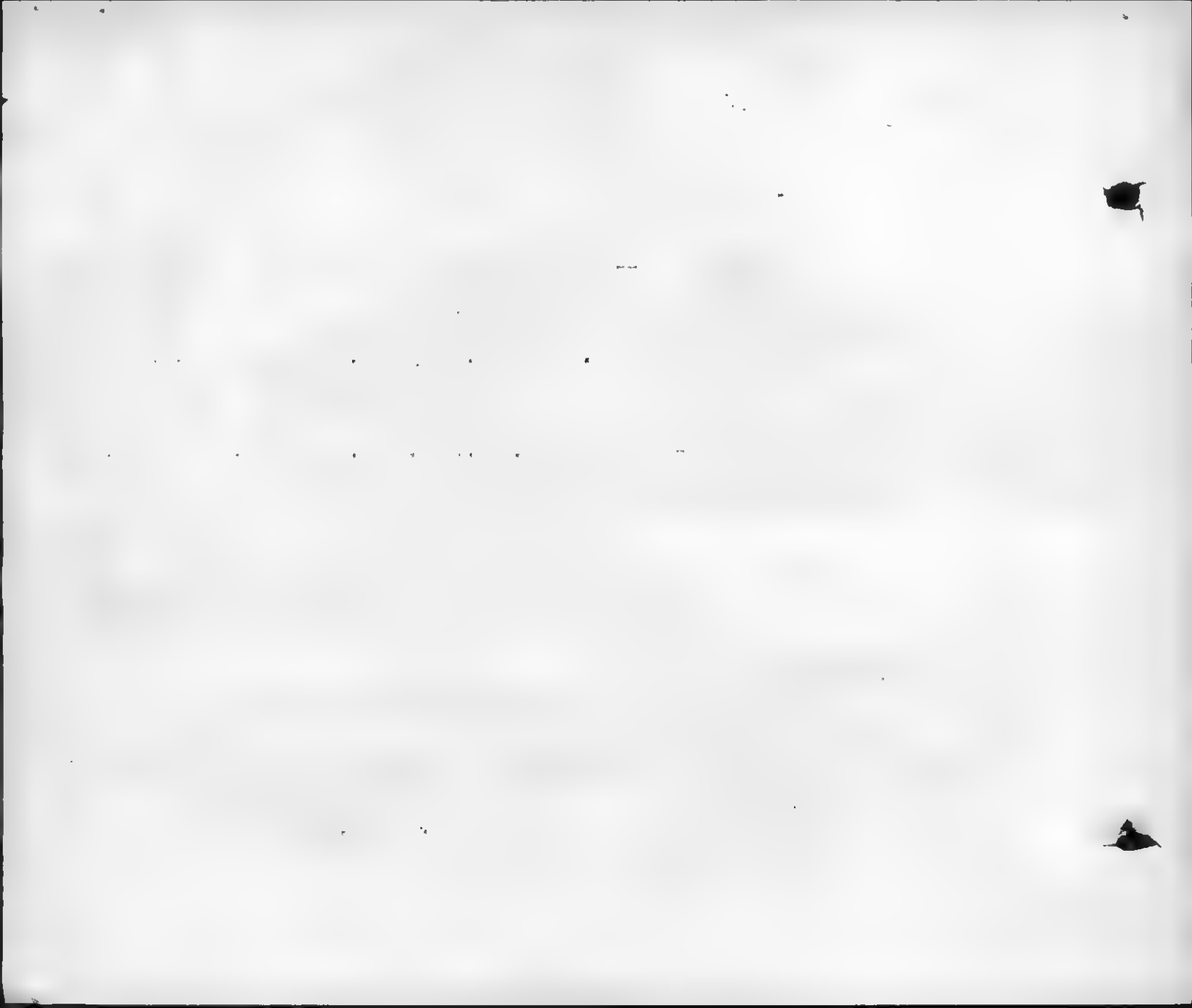
CERTIFICATE OF DEATH

2895

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d STREET ADDRESS 2619 Boone Street	
3 NAME OF DECEASED (Type or print) First Middle Last JAMES THOMAS		4. DATE OF DEATH Month Day Year March 26 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 24, 1886
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY Paper Mfg Co.	
11 BIRTHPLACE (State or foreign country) St. Marys Co., Maryland		12 CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME James Thomas		14 MOTHER'S MAIDEN NAME Charlotte (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-01-1791	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LEFT CEREBRAL THROMBOSIS WITH RIGHT HEMIPARESIS DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Hypertensive Cardiovascular disease			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 24, 19 59 to March 26, 19 59 , and that death occurred at 12:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 3/26/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH Ft. Howard, Md	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH Ft Howard, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 3-31-59	
22c NAME OF CEMETERY OR CREMATORY Baltimore National		22d LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders		ADDRESS 217 E. Preston St. Balto. Md	
24a REC'D BY REGISTRAR APR 2 '59		24b REGISTRAR'S SIGNATURE Charles E. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2896

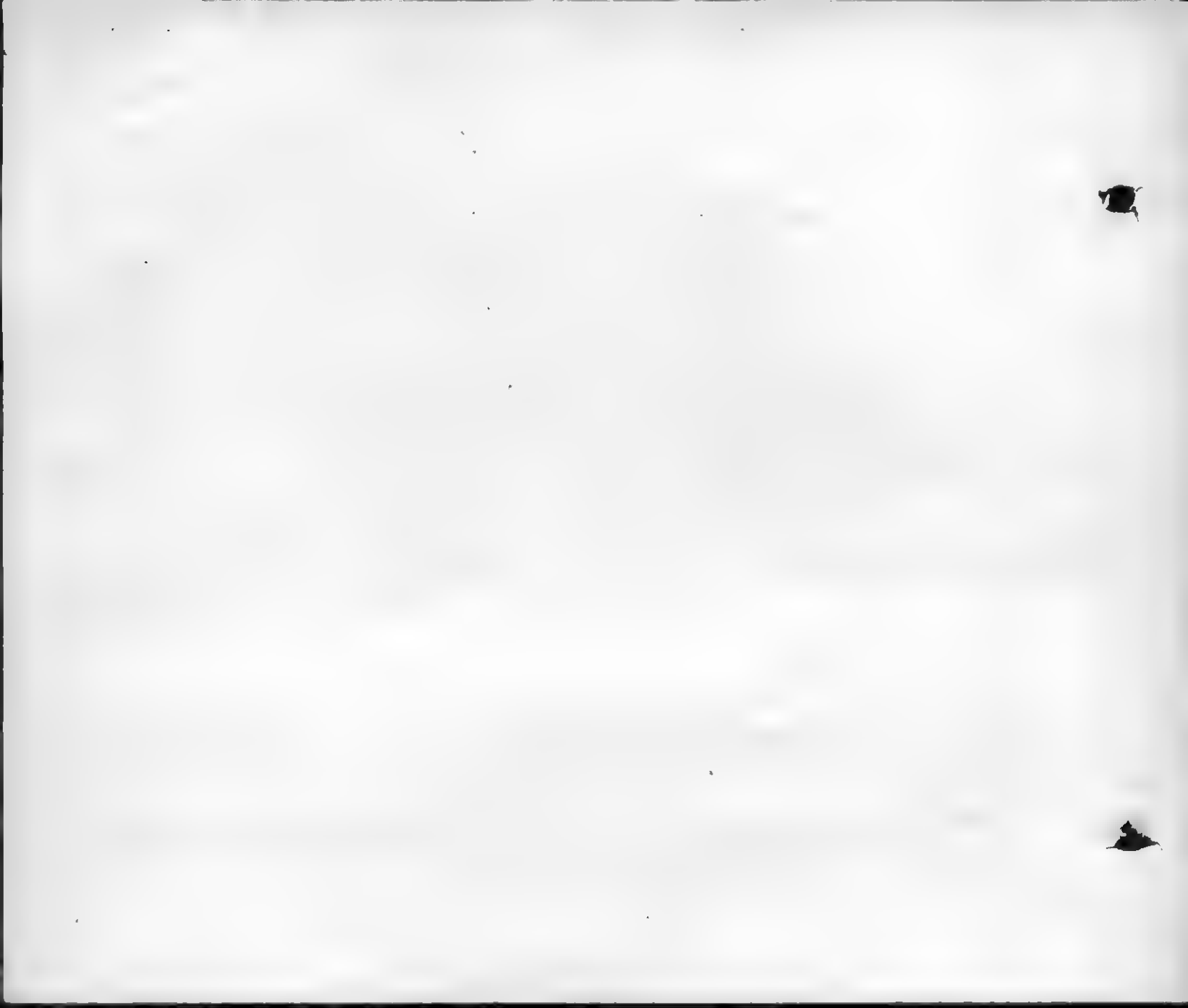
CERTIFICATE OF DEATH

02887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admittance) a. STATE MD. b. COUNTY COMBERLAND	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TRAINING School		d. STREET ADDRESS 318 FAYETTE ST.	
3. NAME OF DECEASED (Type or print) EUGENIE CLARA THURSH		4. DATE OF DEATH MARCH 31 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-24
9. AGE (In years last birthday) 34 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) LEWISTOWN, PA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME GEORGE A. THURSH		14. MOTHER'S MAIDEN NAME DOROTHY BLACK (DEAD)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT ROSEWOOD RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic pneumonia and DUE TO aspiration of blood (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-13-35 to 3-31 , 19 59 , that I last saw the deceased alive on 3-31 , 19 59 , and that death occurred at 3:50 AM, from the causes and on the date stated above			
ACTUAL SIGNATURE Peter W. Rieckert		DATE SIGNED 4-30-59	
PHYSICIAN'S NAME (Type) Peter W. Rieckert		ADDRESS (Street, city or town, state) Baltimore	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2/59	
22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Lewistown, Millin Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR APR 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 26 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hosp ital		d. STREET ADDRESS 412 S. Register St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laura		First Middle Last Tomczak		4. DATE OF DEATH March Month 7 Day Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1899	9. AGE (In years birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME John Tomczak		14. MOTHER'S MAIDEN NAME Julia Kostek		12. CITIZEN OF WHAT COUNTRY? unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT Hospital records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hrs 25 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF DEATH Hour o. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 to March , 19 59 , that I last saw the deceased alive on March 7 , 19 59 , and that death occurred at 12:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove DATE SIGNED 3-7-59 ACTUAL SIGNATURE J D Drinkard M D PHYSICIAN'S NAME (Type) James Donald Drinkard Spring Grove State Hospital					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/10/59		22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY	
23. FUNERAL DIRECTOR'S SIGNATURE George A Weber		ADDRESS 705 S Ann st		24a. REC'D BY REGISTRAR MAR 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02889

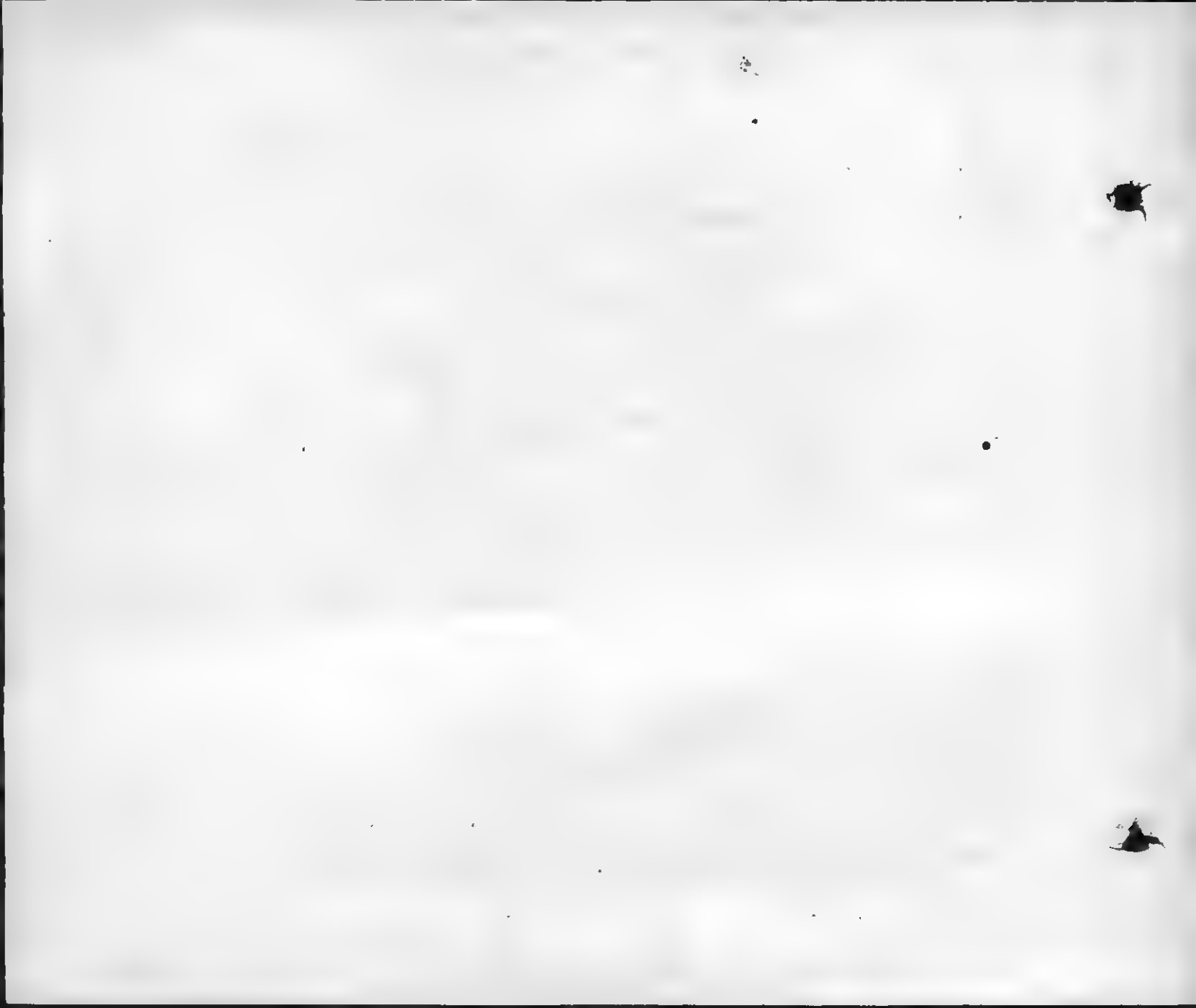
2898

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 315 E. NORTH AVENUE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY d. STREET ADDRESS 315 E. NORTH AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS HENRY TRACEY		4. DATE OF DEATH Month MARCH Day 11 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/83
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCOMOTIVE ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAILWAY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES M. TRACEY		14. MOTHER'S MAIDEN NAME CLARA E. GORDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Uncertain			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 10, 1959 to MARCH 11, 1959 , that I last saw the deceased alive on MARCH 11, 1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____			
ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-14-59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mon. Cook Inc. St Paul & Preston St		24a. REC'D BY REGISTRAR MAR 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2899

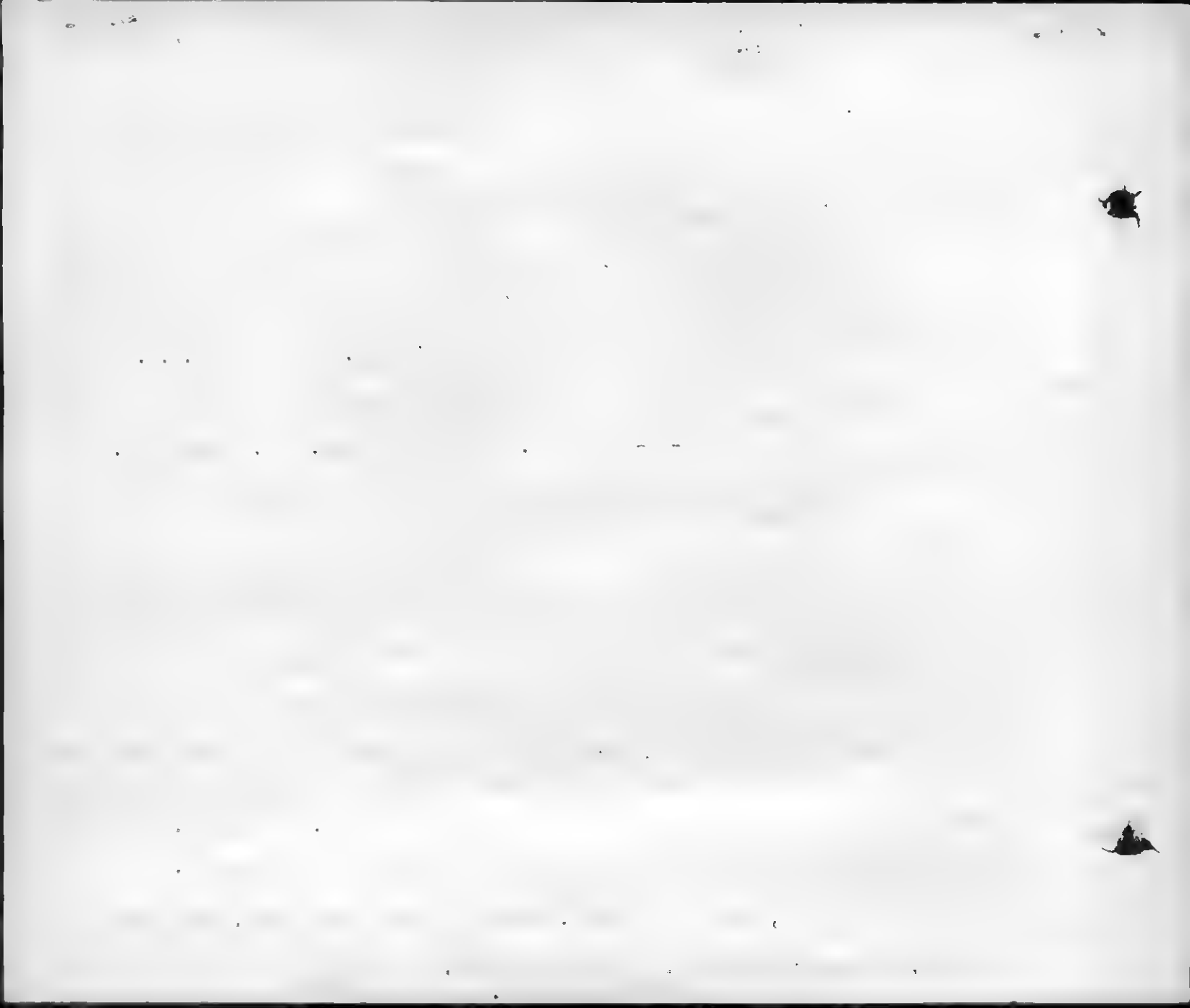
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 60 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Box 571	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last TUCKER		4. DATE OF DEATH Month March Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/95
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas Tucker		14. MOTHER'S MAIDEN NAME Victoria Hammon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 215-10-0560	
17. INFORMANT Clin. Records, VA Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT LUNG WITH METASTASIS XXXXX TO BRAIN AND ADRENALS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2 , 19 59 , to March 3 , 19 59 , and that death occurred at 5:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA Hospital, Ft. Howard, Md.			
ACTUAL SIGNATURE <i>Chien Wei Ian</i>		M.D. VA Hospital, Ft. Howard, Md.	
PHYSICIAN'S NAME (Type) CHIEN WEI IAN		VA Hospital, Ft. Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Asbury Meth. Chruch Cemetery	22d. LOCATION (City town, or county) (State) Broadneck, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson Funeral Home, 1000 Brantley Ave.		24a. REC'D BY REGISTRAR MAR 10 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	
Baltimore, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2900

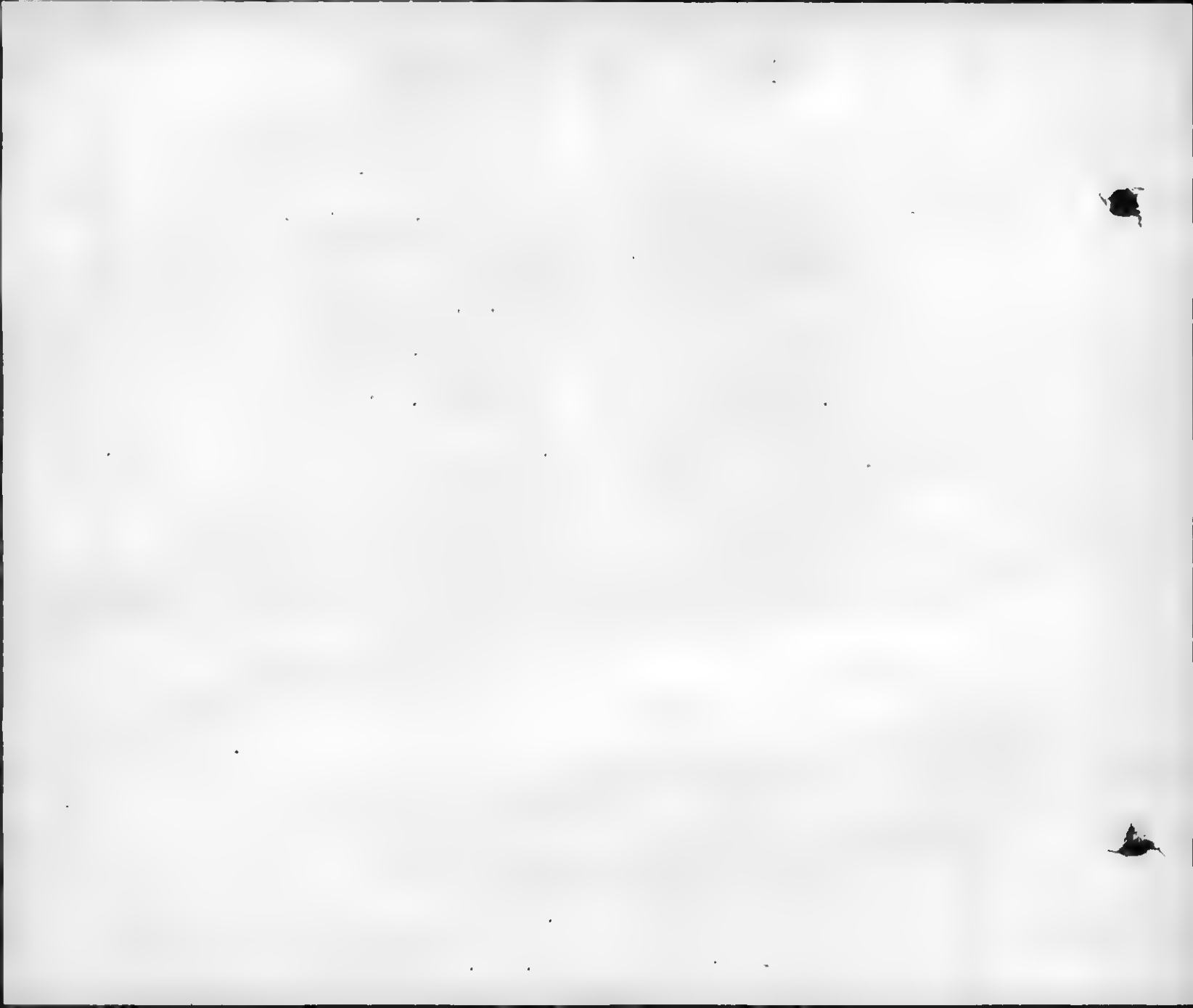
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 224 N. Monroe Street	
3. NAME OF DECEASED (Type or print) CHARLES FREDERICK UHLENBERG		4. DATE OF DEATH Month March Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1868
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman F. Uhlenberg		14. MOTHER'S MAIDEN NAME Mary E. Brockhagen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT C. Edward Hoerichs - 424 Academy Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cronary Thrombosis 430.1 DUE TO Cardio-Vascular Disease & Grade II Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ischemic DUE TO (c) Ischemic		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/8 , 19 59 , to 3/20 , 19 59 , that I last saw the deceased alive on 3/20 , 19 59 , and that death occurred at 4:50 M, from the causes and on the date stated above			
ACTUAL SIGNATURE Eliot W. Johnson M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 34.32 Frederick Ave 3/23/59	
PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON MD Baltimore 29 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR MAR 24 '59	
24b. REGISTRAR'S SIGNATURE Ellsworth Armacost-4600 Liberty Hghts. Ave.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

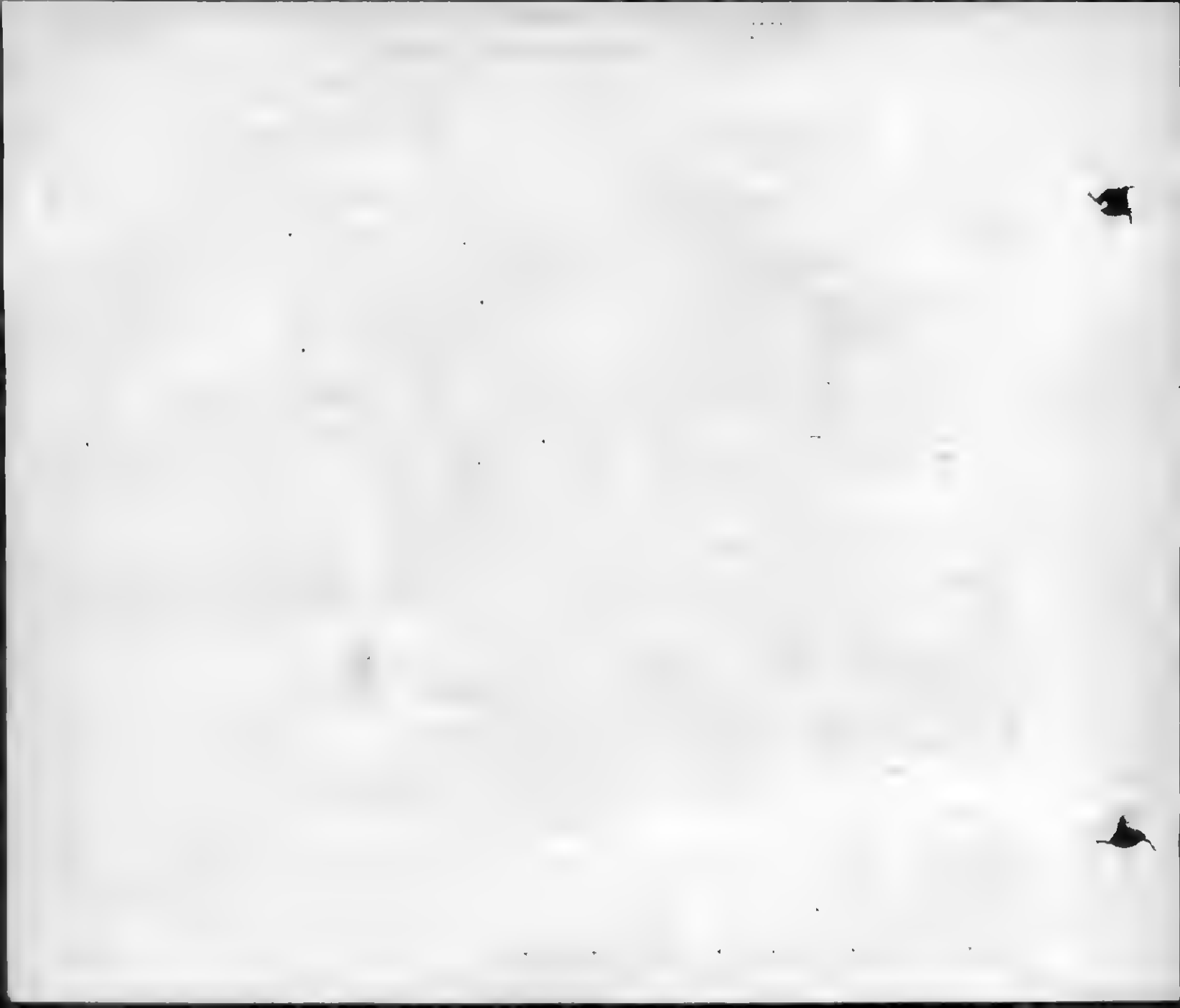
02892

2901

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8001 York Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CAROLINE Middle VANDERMAST Last				4. DATE OF DEATH Month March Day 22 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ernest William Vandermast		14. MOTHER'S MAIDEN NAME Emma Christine Schaake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Address Mr. Adolph Vandermast - 8001 York Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung (secondary) 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the uterus DUE TO (c) abdominal metastases						2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 15, 19 58 to Dec 22, 19 59 that I last saw the deceased alive on Dec 20th, 19 59 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathaniel M. Beck				ADDRESS (Street, city or town, state) 2818 St Paul St Baltimore DATE SIGNED #181MD			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 26, 1959		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC. ADDRESS Balto., Md.				24a. REC'D BY REGISTRAR MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



2724

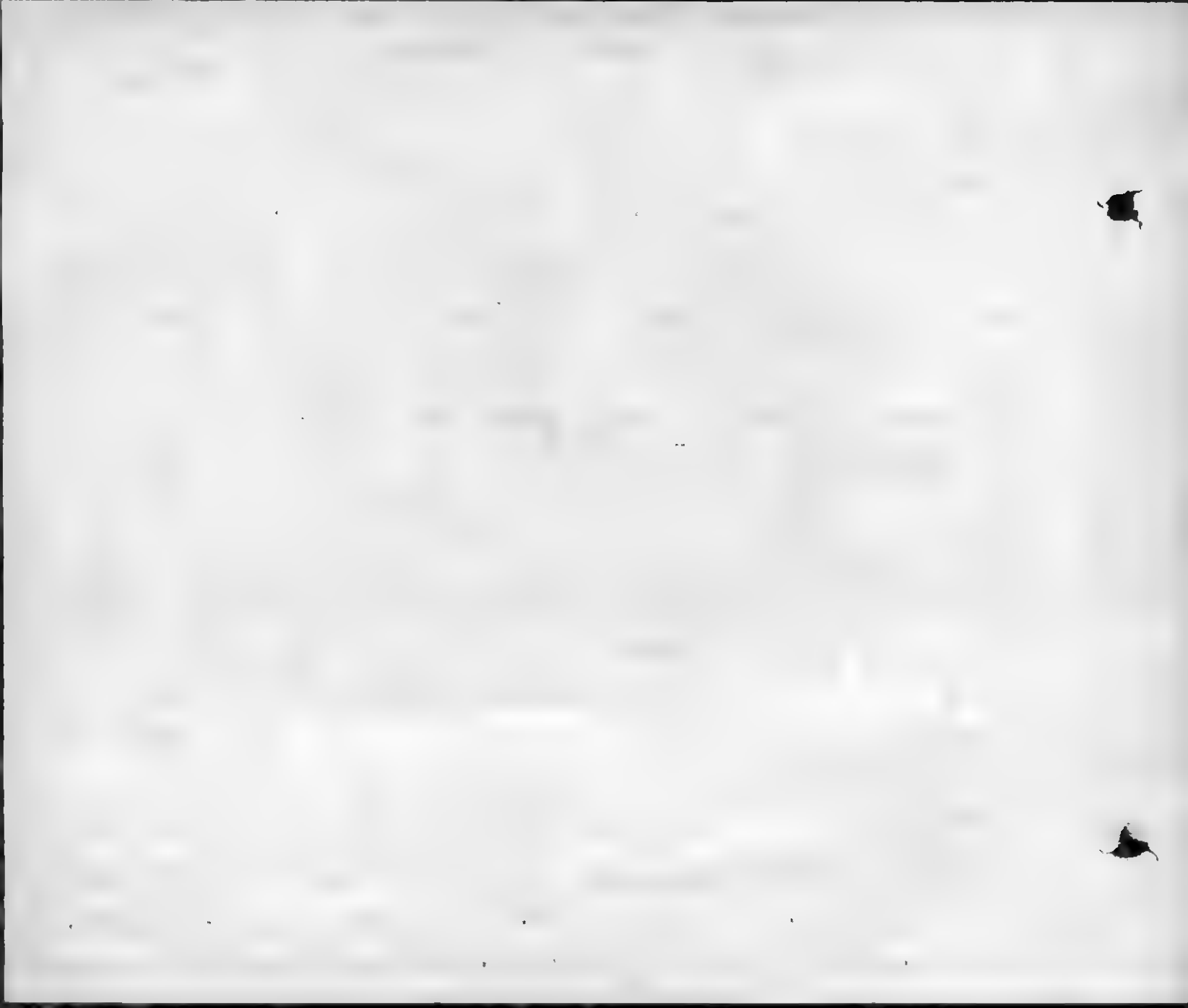
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haleth rope</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>3604 Washington Blvd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3604 Washington Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>A</u> Last <u>Wagener</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1823</u>
9. AGE (In years last birthday) yrs <u>76</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Wagener</u>		14. MOTHER'S MAIDEN NAME <u>Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-22-8113</u>	
17. INFORMANT <u>Henry J Wagener</u>		Address <u>2007 Hollins St Balto Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chr. myocorditis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>190</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>
20f. (City or town) <u>✓</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Aug 13, 1959</u> , to <u>Mar 30, 1959</u> , that I last saw the deceased alive on <u>March 29, 1959</u> , and that death occurred at <u>834</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1014 Frances Ave - Balto - Md.</u> DATE SIGNED ACTUAL SIGNATURE <u>Frederic V. Beiter</u> M.D. PHYSICIAN'S NAME (Type) <u>FREDERIC V. BEITER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Blvd. Elkridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Kenny, Inc</u>		ADDRESS <u>1600 Hollins St. Balto.</u>	24a. REC'D BY REGISTRAR <u>APR 1 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Charles E. King</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

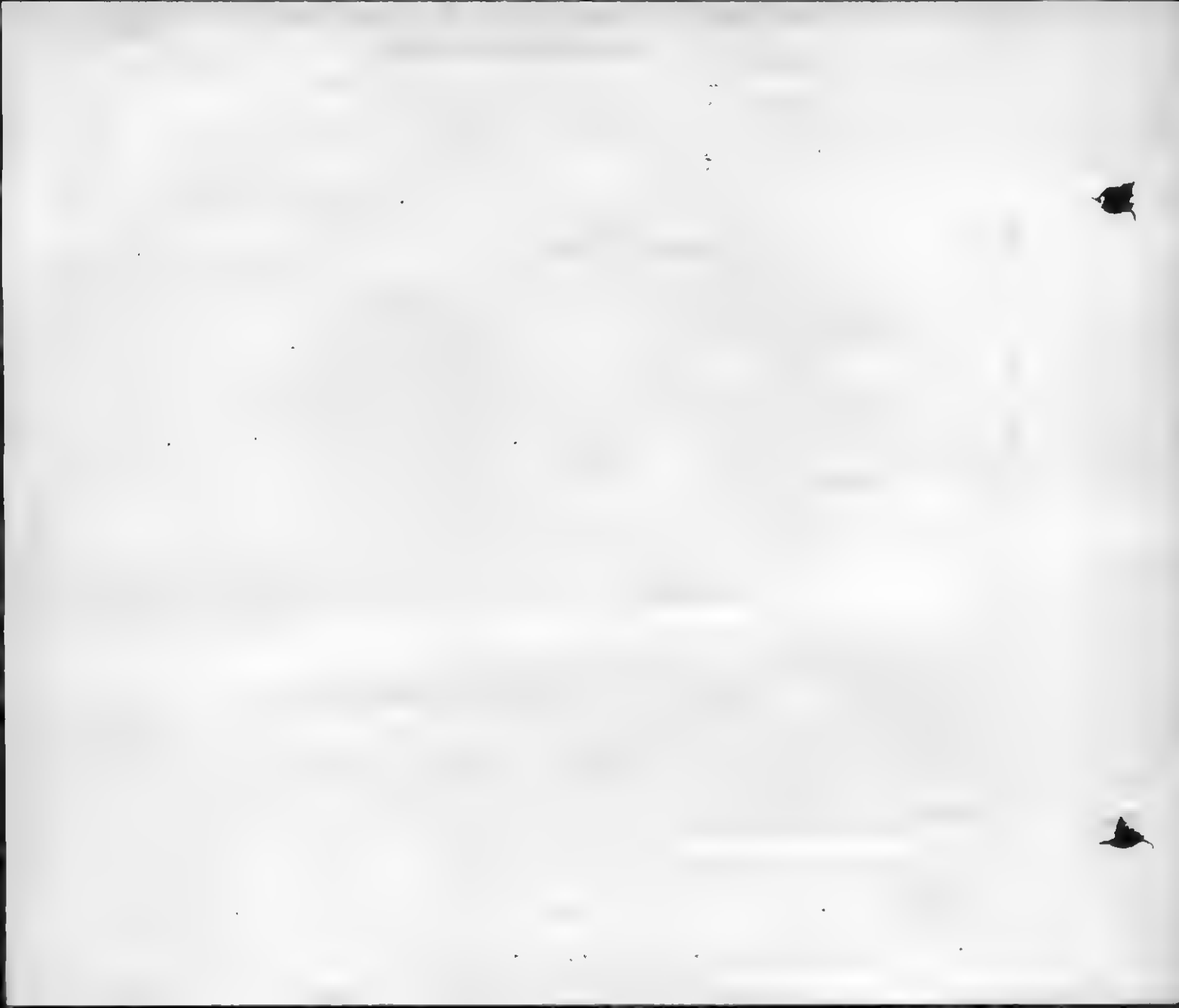
02894

2002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BA LTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 328 S. Augusta Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JULIA Middle AMANDA Last WALDSCHMIDT				4. DATE OF DEATH Month March Day 21 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alpheus Pulley				14. MOTHER'S MAIDEN NAME Sophia Siems			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. 705-05-2979		17. INFORMANT Mrs. Constance Berglund-328 S. Augusta Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 hours 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1953 , to MARCH 31/1959 , that I last saw the deceased alive on MARCH 24, 1959 , and that death occurred at 2 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. H. W. Jupp				ADDRESS (Street, city or town, state) 4808 FREDERICK AVE DATE SIGNED 3/22/59			
NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC.				ADDRESS Balto., Md.		24a. REC'D BY REGISTRAR DA 158 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2 '57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02895

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 3 yrs. d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7609 Gum Road		e. STREET ADDRESS 7609 Gum Road	
3. NAME OF DECEASED (Type or print) Anna (Lillie R. Waller		4. DATE OF DEATH Mar. 3, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1886
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Packer		10b. KIND OF BUSINESS OR INDUSTRY Langs Packg. Co. Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Whitmore		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-4856	
17. INFORMANT Mr. Harry L. Waller		Address 7609 Gum Road 22 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) 3 min (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack E. Collins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack E. Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 5, 59	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2903

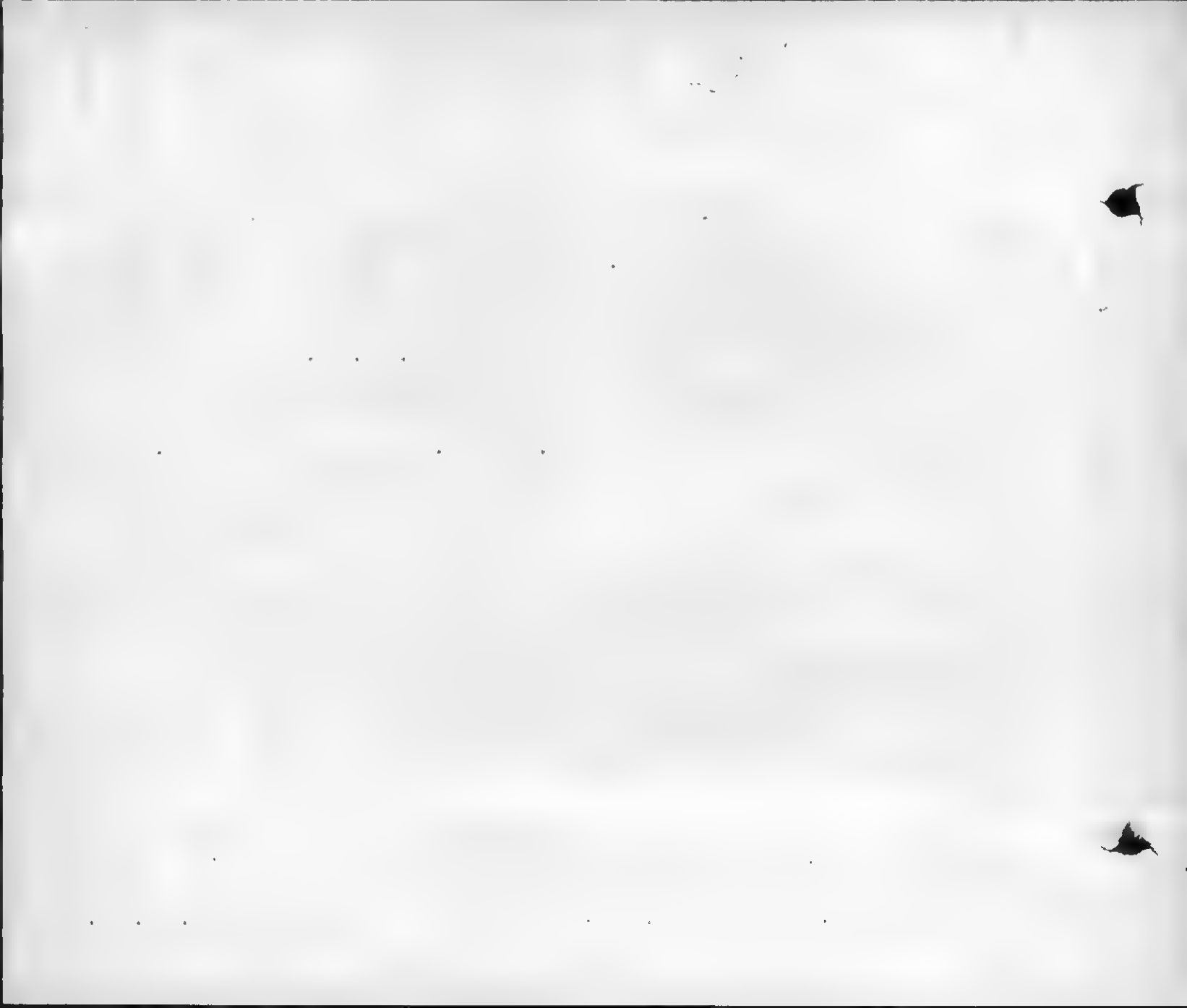
CERTIFICATE OF DEATH

02896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9441 Belair Rd.		d. STREET ADDRESS 9441 Belair Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Selma M. Walter		4. DATE OF DEATH Month Day Year March 10, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Herman Schwartz		14. MOTHER'S MAIDEN NAME Caroline Dietz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Lewis C. Walter		Address 9441 Belair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 8 HOURS 18 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 2, 1948, to MAR. 10, 1959, that I last saw the deceased alive on MAR. 10, 1959, and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Adam G. Lewis M.D. 6232 BELAIR ROAD PHYSICIAN'S NAME (Type) ADAM G. SWISS BALTIMORE 6, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Lutheran		22d. LOCATION (City, town, or county) (State) Perry Hall, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassalle Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2904

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) First Francis Middle L. Last Wandless		4. DATE OF DEATH Month 3 Day 13 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/42
9. AGE (In years last birthday) 17 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Fred Wandless		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Annie Cole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	
16. SOCIAL SECURITY NO		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Yelloweuphritis and hydro-nephrosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:50 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE Peter W. Rieckert M.D.		ADDRESS (Street, city or town, state) 4307 Mainfield Ave Baltimore	
PHYSICIAN'S NAME (Type) Peter W. Rieckert		DATE SIGNED 3-14-59	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-16-59	22c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL	22d. LOCATION (City, town or county) (State) ALLEGANY Co. MD.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight, Cumberland - Md.		24a. REC'D BY REGISTRAR MAR 19 59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

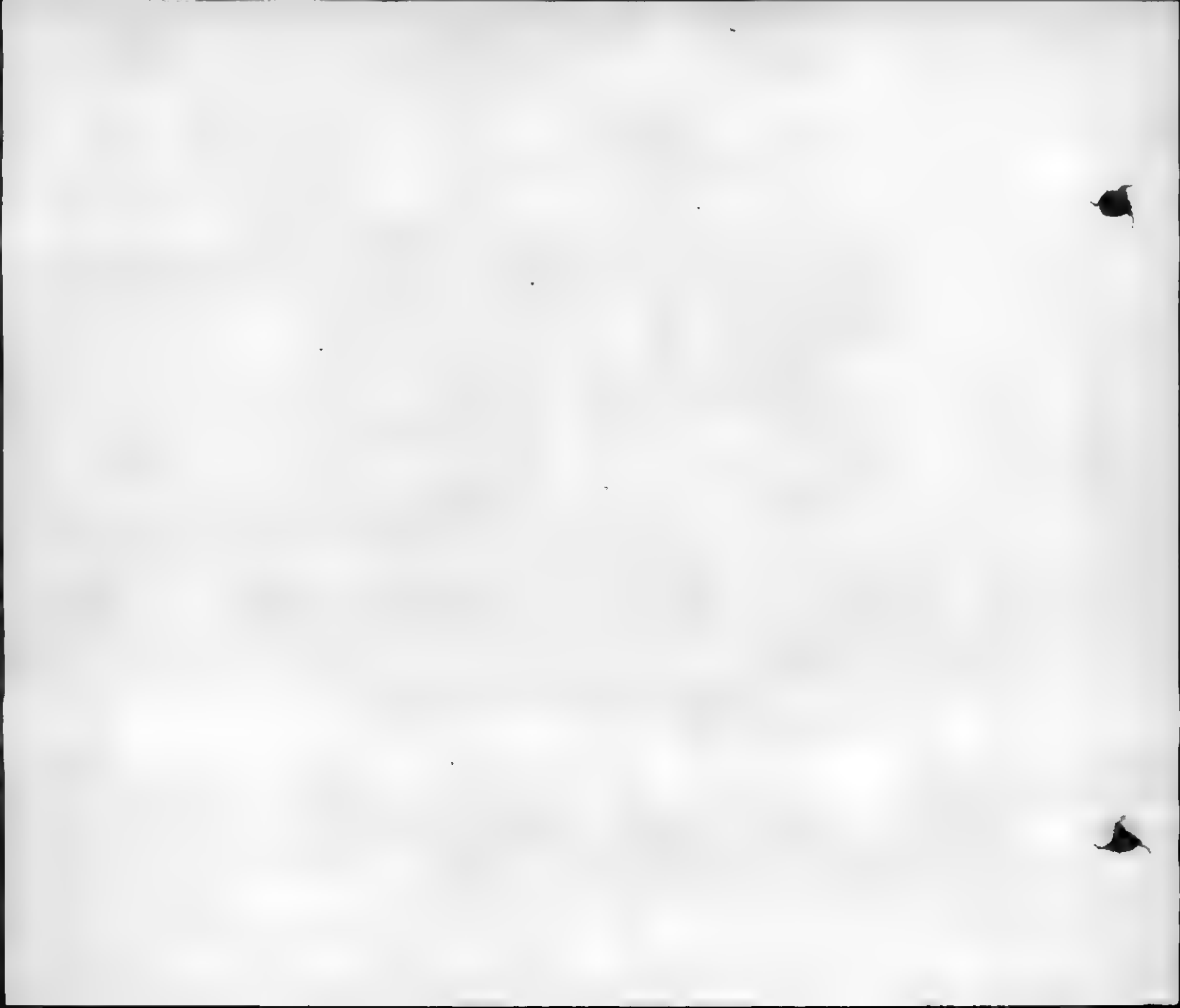
2905

CERTIFICATE OF DEATH

02898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House - in - the Pines</u>				e. STREET ADDRESS <u>Washington Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>Myra E. Waters</u>				4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28 1871</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Waters II</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>		17. INFORMANT <u>Mrs Carter Myers, Knoxville Tenn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3da</u> <u>15 yr. (2)</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-25-1942</u> to <u>3-9-1959</u> , that I last saw the deceased alive on <u>3-8-1959</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				M.D. <u>6209 Frederick Ave.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				<u>Baltimore-26, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 11, 1959</u>		<u>Long Hill Cem.</u>		<u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson</u>				ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

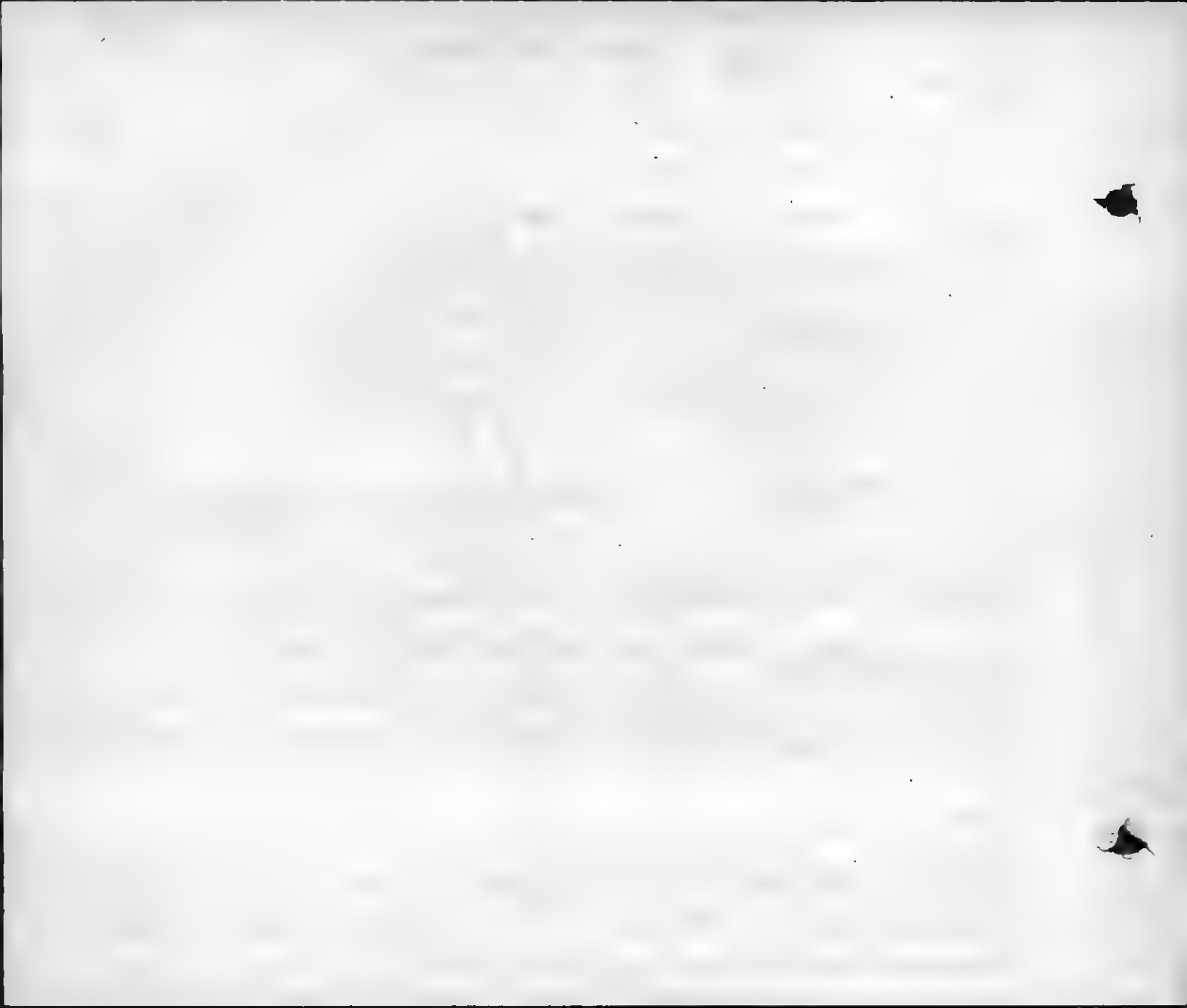
02899

2906

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Zurker Baltimore Rd #1</u>		d. STREET ADDRESS <u>Zurker Baltimore Rd #1</u>	
3. NAME OF DECEASED (Type or print) <u>Georgie Emma Watkins</u>		4. DATE OF DEATH <u>March 12 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 August 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>86</u> yns. IF UNDER 1 YEAR IF UNDER 24 HRS
11. BIRTHPLACE (State or foreign country) <u>Minkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Bryan</u>		14. MOTHER'S MAIDEN NAME <u>Jane Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>219-38486</u>	
17. INFORMANT <u>Ellen Doney - daughter</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>arterio-sclerotic cardiac vasculature</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>over 10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 19 49</u> to <u>March 19 59</u> , that I lost saw the deceased alive on <u>12 March 19 59</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		DATE SIGNED <u>March 12 1959</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>		ADDRESS (Street, city or town, state) <u>Cokeleysville, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>HEREFORD, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson Inc.</u>		24a. REC'D BY REGISTRAR <u>916</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>	



2907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
c. LENGTH OF STAY IN IB 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEY TOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS Route # 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HOLLAND FRANKLIN WEANT		4. DATE OF DEATH Month Day Year 3 31 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1899
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HAMWICK		14. MOTHER'S MAIDEN NAME LOUISE FAAROE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 199-8-065	
17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE BRONCHUS 100.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ART. RHEUMATOID HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 3/31 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/13 1959 to 3/31 1959 , that I last saw the deceased alive on 3/31 1959 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Newcomer		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3, 1959	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Harney Carroll Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE CD Fessenden		ADDRESS Taneytown, Md.	
24a. REC'D BY REGISTRAR APR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2908

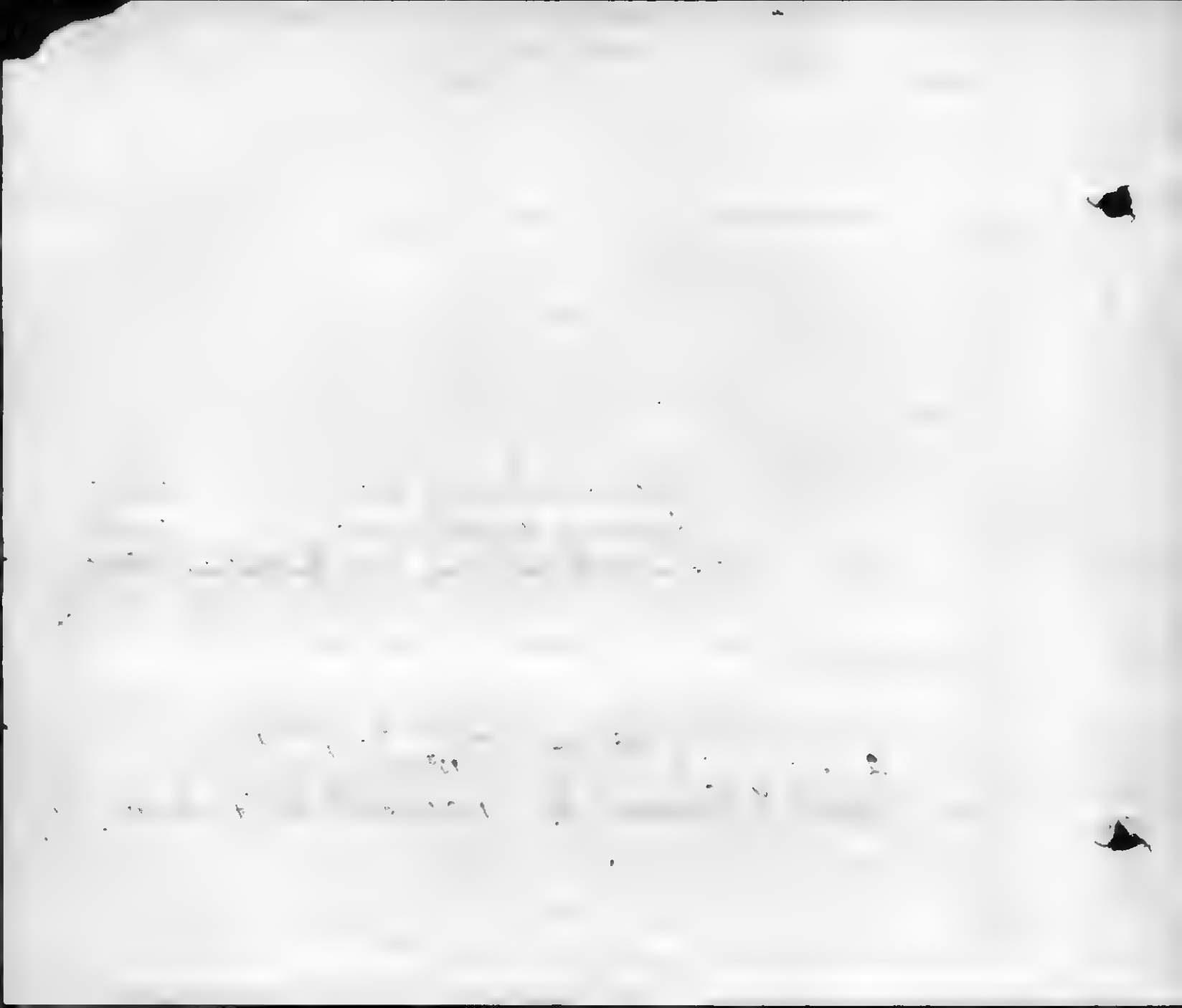
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverton</u>	c. LENGTH OF STAY IN 1b <u>50 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>1608 Riverton Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank</u> <u>Lewis</u> <u>Wick</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>7</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4/1881</u>
9. AGE (If years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Advertising Business</u>	
11. BIRTH PLACE (State or foreign country) <u>Stephensville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank R. Wick</u>		14. MOTHER'S MAIDEN NAME <u>Maude Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>10-10-10</u>	
17. INFORMANT <u>Rm. Burpee</u>		Address <u>9811-467, Richmond</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>1953</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-26</u> , 19 <u>57</u> , to <u>3-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred H. Ossman</u> M.D.		ADDRESS (Street, city or town, state) <u>1101 St Paul St Balto Md</u>	
PHYSICIAN'S NAME (Type) <u>Alfred H. Ossman</u>		DATE SIGNED <u>3-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Mar 10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Balto - E - Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Morris</u>		ADDRESS <u>108 W York - 2</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2909

CERTIFICATE OF DEATH

02902

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Balto.</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1310 Ridge Road</u>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Md</u> b COUNTY <u>Balto.</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d STREET ADDRESS <u>1310 Ridge Road</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna C. Wharton</u> First Middle Last 5 SEX <u>Female</u> 6 CO. OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>9/17/1883</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9 AGE (in years last birthday) <u>75</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		4. DATE OF DEATH <u>March 24</u> 19 <u>59</u> Month Day Year 13 FATHER'S NAME <u>Henry Clark</u> 14. MOTHER'S MAIDEN NAME <u>Chapman</u> 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown, If yes, give war or dates of service) _____ 16 SOCIAL SECURITY NO _____ INFORMANT <u>James H. Wharton</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebral cardiovascular disease</u> DUE TO (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cellulitis + beginning gangrene - Rt. foot.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) _____ 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>February</u> , 19 <u>59</u> , to <u>24 March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>24 March</u> , 19 <u>59</u> , and that death occurred at <u>11:55 P. M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>John A. Nesbitt, Jr.</u> M.D. <u>1118 St Paul St. Baltimore 21</u> DATE SIGNED <u>3-25-59</u> PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3/28/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Western</u> 22d. LOCATION (City, town, or county) <u>Balto. Md</u> (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nab + Son</u> ADDRESS <u>28</u> 24a. REC'D BY REGISTRAR <u>MAR 30 '59</u> DATE <u>March 30 1959</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

2910

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If out of corporate limits, write R.U.P.A. and give nearest town) Idlewylde (Balto. 12)		c LENGTH OF STAY IN 1b Idlewylde (Balto. 12)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1906 Limit Avenue		d STREET ADDRESS 1306 Limit Avenue	
3. NAME OF DECEASED (Type or print) IRVIN W. WILLIAMS		4 DATE OF DEATH Month March Day 20 Year 1959	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 1, 1882
9 AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months 76 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer- retired		10b KIND OF BUSINESS OR INDUSTRY City Water Dept.	11 BIRTHPLACE (State or foreign country) Washington, D.C.
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Unknown	
14 MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?	
16 SOCIAL SECURITY NO None		17 INFORMANT Irvin F. Williams Address 1306 Limit Ave., Balto. 12, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (b) 5 Day (c) 19 DUE TO 19 cause last, (c) 19		INTERVAL BETWEEN ONSET AND DEATH 5 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from, Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Arthur E. Kneass		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Arthur E. Kneass		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/24/59	
22a BURIAL, CREMATION, REMOVAL (Spec. fy) Burial		22b DATE THEREOF Mar. 25, 1959	
22c NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a REC'D BY REGISTRAR MAR 26 '59	
24b REGISTRAR'S SIGNATURE Arthur E. Kneass			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2911

CERTIFICATE OF DEATH

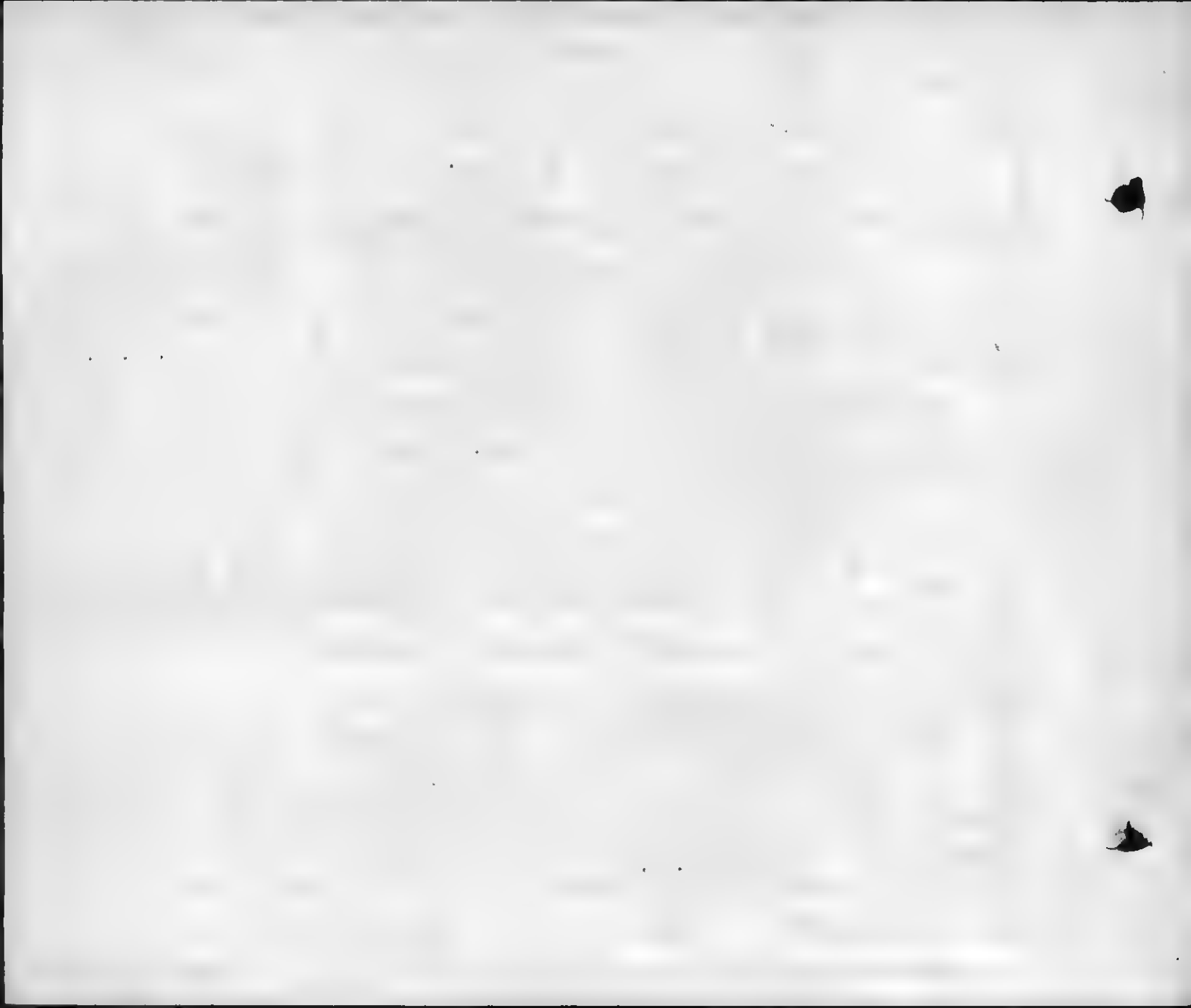
04101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res'dence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Williams Last Williams		4. DATE OF DEATH Month March Day 29 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR: Months 56 Days 56 Hours 56 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stenographer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Faust		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955 , to March 29, 1959 , that I last saw the deceased alive on March 29, 1959 , and that death occurred at 9:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-30-59			
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-15-59	
22c. NAME OF CEMETERY OR CREMATORY U. S. Ind. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG240 4-3-59 et

02905

CERTIFICATE OF DEATH

2912

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		STATE <u>MD.</u> COUNTY <u>✓</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>BALTO.</u>		TOWN <u>BALTO.</u>	
TOWN <u>FULLERTON</u>		<u>2 1/2 MONTHS</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FULLERTON NURSING HOME</u>				STREET ADDRESS <u>3907 HUDSON ST</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANDREW</u>		(Middle) <u>WILLNER</u>		(Last) <u>WILLNER</u>		(Month) (Day) (Year)	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>4/28/1868</u>	
9. AGE last birthday <u>90</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>STANDARD OIL CO.</u>		<u>GERMANY</u>		<u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN WILLNER</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Wm. ROWE, 523 St. FRANCIS RD (4)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pericarditis Sigmoid</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec. 29 1958</u>		19b. MAJOR FINDINGS OF OPERATION <u>Pericarditis - sigmoid - (dissecting) done</u>		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11:20</u> , 19 <u>59</u> , to <u>2:11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2:11</u> , 19 <u>59</u> , and that death occurred at <u>9:34</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Arthur S. Hoffmann</u>				ADDRESS (Street, city, town, state) <u>M.D. 4414, Baltimore & Potomac Co. Md.</u>			
DATE SIGNED <u>3/28/59</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3/31/59</u>		NAME OF CEMETERY OR CREMATORIUM <u>OAK LAWN</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Hoffmann</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C.F. Hoffmann</u>		ADDRESS <u>3218 HUDSON ST.</u>	
DATE <u>MAR 30 '59</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled out by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII A1EC 1-55 10M



2913

CERTIFICATE OF DEATH

Reg. Dist. No.

02906

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7101 Campfield Road</u>		d. STREET ADDRESS <u>5310 Catalpha Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. <u>Marie B. Wilson</u>		4. DATE OF DEATH <u>March 13, 19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Malone</u>		14. MOTHER'S MAIDEN NAME <u>Mary Craig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. William Mader, 7101 Campfield Road.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 12, 19 59</u> , to <u>MARCH 13, 19 59</u> , that I last saw the deceased alive on <u>MARCH 12, 19 59</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel P. Scalia</u>		ADDRESS (Street, city or town, state) <u>1331 REISTERSTOWN ROAD</u> DATE SIGNED <u>3-13-59</u>	
PHYSICIAN'S NAME (Type) <u>PIKESVILLE 8 MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

112

Name of deceased		Date of death	
John J. Smith		Nov. 10, 1917	
Age		35 years	
Sex		Male	
Race		White	
Place of birth		Boston, Mass.	
Usual residence		Boston, Mass.	
Cause of death		Pneumonia	
Place of death		Home	
Physician		Dr. J. H. Smith	
Burial place		Catholic Cemetery	
Burial date		Nov. 15, 1917	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Date of registration		Nov. 12, 1917	
Registrar's office		Boston, Mass.	

2914

CERTIFICATE OF DEATH

02907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>House in Pines Nursing Home</u>				d. STREET ADDRESS <u>609 N. Highland Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Edgar</u> First <u>M.</u> Middle <u>Wolfe, Sr.</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 9, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min. <u>59</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>8</u> Hours <u>15</u> Min. <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Annie Crouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>Mrs. Mabel Evans, 1509 Cranwell Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> (c) <u>Generalized atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs. (3)</u> <u>10 yrs. (3)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-21-1958</u> to <u>3-5-1959</u> , that I last saw the deceased alive on <u>3-4-1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>6209 Frederick Rd.</u>				DATE SIGNED <u>3-5-59</u>			
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>				M.D. <u>Baltimore-28, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.J. Ruck, Inc.</u> ADDRESS <u>5305 Harford Rd. #14</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

